

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

127229

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>517 Albany Avenue Oakhaven Convalescent Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3806 Albemarle St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edna Reed Aitcheson</u>		<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>5</u> Year <u>1961</u>		<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec. 5, 1894</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>66</u> <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Stenographer - clerk</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Govt</u>			
<b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Edwin Reed</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Bertha Shertz</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>579-18-8421</u> <b>17. INFORMANT</b> <u>Caroline Aitcheson, 3806 Albemarle St N.W., Wash. D.C.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>443 X</u> <b>IMMEDIATE CAUSE (a)</b> <u>Cerebral Embolism</u> DUE TO <u>Hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Arterial fibrillation</u> <b>DUE TO (b)</b> <b>DUE TO (c)</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>sudden</u> <u>30 yrs</u> <u>few days?</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>0</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>1956</u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11/6/61</u> <b>to</b> <u>11/5/61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11/6/61</u> <b>and that death occurred at</b> <u>358</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Chas. H. Wolohon, MD</u> <b>M.D.</b>		<b>22b. DATE SIGNED</b> <u>  </u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Chas. H. Wolohon</u> <b>22d. ADDRESS</b> <u>7600 Carroll Ave Takoma Park, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/8/1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bethel Cemetery</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Company-2901 14th St., N.W.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 8 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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The S. E. Harris Company - Washington, D. C.

ATTENTION, ATTENTION.

TO CRIMINAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death and that the cause of death be determined by the attending physician and completed and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12743					12730				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <b>MONTGOMERY</b>					a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>					b. COUNTY <b>MONTGOMERY</b>				
c. LENGTH OF STAY IN b. <b>4 DAYS</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING, MD.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WHEATON NURSING HOME</b>					d. STREET ADDRESS <b>9404 BRUCE DR.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>MARTHA OLIVIA ALMQUIST</b>					4. DATE OF DEATH Month <b>11/</b> Day <b>28</b> Year <b>1961</b>				
5. SEX <b>FEMALE</b>					6. COLOR OR RACE <b>WHITE</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>9/10/82</b>				
9. AGE (In years last birthday) <b>79 yrs.</b>					IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>SWEDEN</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>FRANK NOREN</b>					14. MOTHER'S MAIDEN NAME <b>WHILHELMINA PETERSON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES OR SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					17. INFORMANT Address <b>5413 31st Street N.W.</b> <b>Mr. John R. Almquist Washington D.C.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>Acute cardiac decompensation</b> <b>Generalized arteriosclerosis</b> <b>(Malnutrition)</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <b>750.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Generalized arteriosclerosis</b> <b>(Malnutrition)</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>September, 1961</b> , to <b>November 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>November 28, 1961</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Bennet A. Porter, Jr.</b>					22b. DATE SIGNED <b>November 28, 1961</b>				
22c. PHYSICIAN'S NAME (Type) <b>BENNET A. PORTER JR.</b>					22d. ADDRESS <b>9301 Coleville Rd, Silver Spring, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					23b. DATE THEREOF <b>12/1/61</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>					23d. LOCATION (City, town or county) (State) <b>PRINCE GEORGE'S COUNTY, MARYLAND</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>					25a. REC'D BY REGISTRAR <b>NOV 30 '61</b>				
25b. REGISTRAR'S SIGNATURE <b>Warner E. Pumphrey</b>									

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(McIntosh)

James A. McIntosh

WINTER 4, NUMBER 22

THE NEW YORK OBSERVER

NEW YORK OFFICE, 100 NASSAU ST., NEW YORK 1, N.Y.  
SILVER SPRING, MARYLAND



Charles L. Evans

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12745						12732					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>9 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Lowndes</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Valdosta</b> d. STREET ADDRESS <b>1709 Charlton Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>WILEY ROBERT ARNOLD</b>						4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 12, 1927</b>		9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months <b>34</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Credit Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Donald R. Arnold</b>						14. MOTHER'S MAIDEN NAME <b>Lillie M. Stalvey</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>256-26-9240</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aortic insufficiency</b> 7-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Rheumatoid spondylitis &amp; aortitis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> <b>16 years</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 19, 1961</b> to <b>Nov. 28, 1961</b> that (I) (we) last saw the deceased alive on <b>Nov. 28, 1961</b> , and that death occurred <b>2:20 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Paul A. Ebert, M.D.</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>11/29/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Paul A. Ebert</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
<b>Burial-transit 11-29-61</b>				<b>Sunset Hill Cemetery</b>		<b>Valdosta, Georgia</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>						ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	



Montgomery

Bethesda

The Clinical Center

WILLIAM

ROBERT

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November 2, 1957

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Info

Credit Report

Donald E. Arnold

to

256-1-2250 The Clinical Center, Bethesda, Md.  
The Medical Record  
Lillian H. Arnold

Georgia

USA

Public Information

Annual Information

x

November 19, 1957

Nov. 26, 1957

Full Report

The Clinical Center, Bethesda, Md.  
Institute of Health, Bethesda, Md.

Bureau of Health Statistics, Georgia

ROBERT A. EMERSON, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>8600-2nd Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Hattie C. Babbitt</b>		4. DATE OF DEATH <b>Nov. 8, 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1892</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Auditor U.S. Gov't.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G.A.O.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Amanda--</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Edward F. Babbitt</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral infarction</b> (c) <b>Cerebral and generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive &amp; arteriosclerotic heart disease - auricular fibrillation</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-20</b> , 19 <b>59</b> to <b>11-8</b> , 19 <b>61</b> that (I) <b>(see)</b> last saw the deceased alive on <b>11-7</b> , 19 <b>61</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Jason Geiger</b>		22b. DATE SIGNED <b>11-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jason Geiger</b>		22d. ADDRESS <b>1110 Spring Street, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery Prince Georges County, Md.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.-2901 14th St., N.W.</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 9 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12747

12734

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> <b>37 Days</b> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if different residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>East Orange</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>139 North Arlington Avenue</b> d. STREET ADDRESS e. IS RESIDENCE ON FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>CHARLES JOHN BACHMAN</b> First Middle Last <b>4. DATE OF DEATH</b> <b>November 14, 1961</b> Month Day Year			<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>February 13, 1906</b> <b>9. AGE</b> (In years last birthday) <b>55</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Engineer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Education</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pennsylvania</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			<b>13. FATHER'S NAME</b> <b>Paul Bachman</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Nellie Bailey</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>Not Available</b> <b>17. INFORMANT</b> <b>The Medical Record</b> <b>Address</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aortic Insufficiency</b> DUE TO (c) <b>Rheumatic Heart Disease - Inactive</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Low urinary tract obstruction (Prostatic hypertrophy)</b>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>October 8, 1961</b> <b>November 14, 1961</b> (County) (State)			<b>21. I certify that</b> <b>he</b> (this hospital) <b>attended the deceased from</b> <b>Nov. 11, 1961</b> <b>8:10A.M.</b> <b>that</b> <b>he</b> (we) <b>last saw the deceased alive on</b> <b>Nov. 11, 1961</b> <b>and that death occurred at</b> <b>Nov. 14, 1961</b> <b>from the causes and on the date stated above.</b>		
<b>22a. SIGNATURE</b> <b>W. Douglas Clark</b> <b>M.D.</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>W. Douglas Clark</b>			<b>22b. DATE SIGNED</b> <b>November 14, 1961</b> <b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial-transit 11-15-61</b> <b>23b. DATE THEREOF</b> <b>Great Valley Presby.Cem.</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Malvern, Penna.</b> <b>23d. LOCATION</b> (City, town or county) (State)			<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. PUMPHREY</b> <b>Bethesda, Md.</b> <b>25a. REC'D BY REGISTRAR</b> <b>NOV 16 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Travis</b>		

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of available The Clinical Center, Bethesda, Maryland

Education Engineer

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editors:

February 13, 1965

November 1941

September 1996

239 North Main Street

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12748						12735					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Montgomery						a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park						b. COUNTY Prince George					
c. LENGTH OF STAY IN 1b DOA						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University XXXX Park					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital						d. STREET ADDRESS 4411 Tuckerman Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH		Month		Day Year	
First Middle Last Harold Cullen Baird						November 2		19		61	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1905		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Consultant				11b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Alba, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry C. Baird						14. MOTHER'S MAIDEN NAME Cora Patton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 440-01-3466		17. INFORMANT Washington Sanitarium and Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 287X DUE TO OBESITY, MARKED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GOUT, CHRONIC											
INTERVAL BETWEEN ONSET AND DEATH 3 mos. 20 yrs.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to 2 Nov. 1961, that (I) (we) last saw the deceased alive on 2 Nov. 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE L.B. Snow						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/2/61	
22c. PHYSICIAN'S NAME (Type) Lee B. Snow						22d. ADDRESS 7950 New Hamp Ave Langley Park					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov 6, 1961		23c. NAME OF CEMETERY OR INTERMENT PLACE Columbia Gardens				23d. LOCATION (City, town or county) Arlington Va	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons						ADDRESS Hyattsville Md.		25a. REC'D BY REGISTRAR DATE NOV 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

15M82

15M82

610-01-3606

1967, 1961 Columbia missions  
1967, 1961 Columbia missions  
1967, 1961 Columbia missions



VS. A15ME  
5M 7/59

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12736

12736

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Oregon</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		b. COUNTY <b>Clatsop</b>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Portland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>709 So. Belgrade, Kemp Mill Estates</b>		d. STREET ADDRESS <b>1723 N.E. 10th Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Edgar</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1890</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant Own store</b>		12. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>	
13. FATHER'S NAME <b>Samuel Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Emma Frenthrup</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Verna E. Barnes</b>		18. ADDRESS <b>1723 N.E. 10th Avenue Portland Oregon</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of previous heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		23. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		25. (City or town) (County) (State)	
26. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		27. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 28. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 29. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 30. DATE SIGNED <b>11/21/61</b>	
31. ACTUAL SIGNATURE <b>Frank J. Broschart</b>		32. EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>	
33. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANSIT-BURIAL 11/27/61</b>		34. DATE THEREOF <b>11/27/61</b>	
35. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		36. LOCATION (City, town, or country) (State) <b>Portland Oregon</b>	
37. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		38. ADDRESS <b>8434 GEORGIA AVENUE SILVER SPRING, MARYLAND</b>	
39. REC'D BY REGISTRAR <b>NOV 22 '61</b>		40. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

THE STATE  
HEALTH DEPT.

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REPORT  
GIVE DATE

509 St. Lawrence, New York

July 21, 1920

Illness

Brain Strain

107 St. Lawrence, New York

Brain Strain

It is of your own best interest

Illness

Brain Strain

107 St. Lawrence, New York

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FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Montgomery		Germananton - R-2		md		Montg	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
M		Seneca Rd.		06 Germananton		R-2	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
First Middle Last		Month Day Year					
JOSEPH LEROY BEACH JR		Nov 23 1961					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
male		white				8-3-59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Jan Henry Beach				2 yrs		Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				11-S-C	
md							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
Jan Henry Beach		Jane E. Lowery					
17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
Joe L. Beach		Stim 2					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
		Burial		11/26/61		Darnestown Church Cemetery Darnestown, Montg., Maryland	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home- 1331 E. Montg. Ave. Rockville, Md.		DA NOV 27 '61		Arthur S. Kraus			

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James Wheeler - General Agent - Louisville, Ky.

15883

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FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12751 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12738

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>1 yr</u>				d. STREET ADDRESS <u>1416 Flora Terrace</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1416 Flora Terrace</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Roy</u>		4. DATE OF DEATH <u>Nov 18 1961</u>		5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-13-95</u>		9. AGE (In years last birthday) <u>66 yrs.</u>		IF UNDER 1 YEAR: Months <u>11</u> Days <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Heurich Brewery</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>George Beasley</u>				14. MOTHER'S MAIDEN NAME <u>Molly Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW-1</u>				16. SOCIAL SECURITY NO. <u>578-07-7442</u>			
17. INFORMANT <u>Mildred E. Beasley (wife)</u>				Address <u>Stn 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (c) <u>hypertension</u> cause test. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C. A. Left lung - 2 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>11-18-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/22/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u>			
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> ADDRESS <u>8434 GEORGIA AVENUE</u>				24a. REC'D BY REGISTRAR <u>NOV 21 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey</u>							



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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "STATION" and "OFFICE" are faintly visible.]*

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12752

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12739

Item 15 Film G501 11/20/61 iw

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <i>md</i>		b. COUNTY <i>montg</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>D.O.A.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville - manor Club-</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Montg Gen. Hosp</i>		d. STREET ADDRESS <i>14631 Crossway Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Humphrey Beckett</i>		4. DATE OF DEATH <i>Nov 2 1961</i>		5. SEX <i>male</i>	
6. COLOR OR RACE <i>white</i>		7. B. DATE OF BIRTH <i>7-1-1878</i>		9. AGE (In years last birthday) <i>83</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DR. Gen. Ret</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Lanham md.</i>	
13. FATHER'S NAME <i>Humphrey Beckett</i>		14. MOTHER'S MAIDEN NAME <i>Yvonne Lanham</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of discharge) <i>no</i>		16. SOCIAL SECURITY NO. <i>yes Inactive Reserve</i>		17. INFORMANT <i>Margaret Murray (daughter) Item 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschant</i>		M.D.		DATE SIGNED <i>11-2-61</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/> Burial		22b. DATE THEREOF <i>11/6/61</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Whitfield Church</i>	
22d. LOCATION (City, town, or country) <i>Lanham,</i>		(State) <i>Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 6 '61</i>	
23. FUNERAL DIRECTOR <i>Francis Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

(M)

(1)

Francis G. Jones, Nashville, Tenn.

Box 100

Whitefield, Tenn.

Lebanon

Lebanon

Box 100

Box 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12753

12740

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN lb <b>5 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BROOKEVILLE</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES EDWARD BENSON</b>			4. DATE OF DEATH Month Day Year <b>11 22 19 61</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		8. DATE OF BIRTH <b>12/8/67</b>	
13. FATHER'S NAME <b>JAMES BENSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ALLNUTT</b>		9. AGE (In years last birthday) <b>93</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>arteriosclerotic Cardiovascular Disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>tumor of sigmoid colon (prob carcinoma)</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/16</b> , 19 <b>61</b> , to <b>11/22</b> , 19 <b>61</b> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>11/21</b> , 19 <b>61</b> , and that death occurred at <b>9A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>J.P. Martin, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-22-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J.P. MARTIN, M.D.</b>				22d. ADDRESS <b>MEDICAL CENTER SANDY SPRING, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-25-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Brookeville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis X. Barber</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 29 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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FOR STATE  
HEALTH DEPT.

TOTAL DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12741  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>7 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>montg</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>18 Takoma Park</i> d. STREET ADDRESS <i>17520 maple ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <i>Virginia Lynne Brigg</i>		4. DATE OF DEATH Month <i>nov</i> Day <i>25</i> Year <i>1961</i>		5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-16-43</i>		9. AGE (In years last birthday) <i>18</i> yrs.		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>10</i> Hours <i>0</i> Min. <i>0</i>		11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>DC</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Temple E. Brigg</i>				14. MOTHER'S MAIDEN NAME <i>Mary Wells</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT <i>Hosp Records</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Continued Cerebral Contusion &amp; laceration</i> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Fracture of skull</i> DUE TO (c) <i>Auto accident</i> INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Acute Bacterial pneumonia</i>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <i>Was prisoner in car which left highway &amp; struck a tree</i>															
20c. TIME OF INJURY Month, Day, Year Hour <i>3:55</i> a.m. <i>11-25-1961</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>street</i>				20f. (City or town) <i>Silver Spring - Montg md</i> (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Frank J. Bloch</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED							
EXAMINER'S NAME (Type) <i>FRANK J. Bloch</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <i>11-26-61</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>Nov 28, 1961</i>				22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>				22d. LOCATION (City, town, or country) (State) <i>PRINCE GEORGES CO. MD.</i>							
23. FUNERAL DIRECTOR <i>Arthur S. Francis</i>				ADDRESS <i>254 Carroll St NW</i>				24a. REC'D BY REGISTRAR <i>Arthur S. Francis</i>				24b. REGISTRAR'S SIGNATURE							

1951

STATE OF NEW YORK

1951

OFFICE OF THE  
ATTORNEY GENERAL

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12755

## CERTIFICATE OF DEATH

Reg. Dist. No. 12742

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>123 Grafton St.</u>				d. STREET ADDRESS <u>123 Grafton St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>C.</u> Last <u>BIRD</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21, 1868</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Clarke</u>				14. MOTHER'S MAIDEN NAME <u>Martha Dillinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>123 Grafton St., Chevy Chase, Md.</u> <u>Miss Elizabeth Bird</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 422.1 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1949, to Nov. 25, 1961, that I last saw the deceased alive on Nov. 23, 1961, and that death occurred at 4:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Delwitt E. DeLaughter</u> M.D. <u>3848 Porter St. N.W. Wash. D.C.</u> <u>11-25-61</u> PHYSICIAN'S NAME (Type) <u>Delwitt E. DeLaughter, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Nov. 25, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Rd., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chong Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
12756		12743	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>1903 Minnesota Ave., S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph Birnman</b>		4. DATE OF DEATH <b>November 30, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1890</b> 9. AGE (In years last birthday) <b>71</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Russia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jout Birnman</b>		14. MOTHER'S MAIDEN NAME <b>Sylvia Libby</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Jack Birnman, 11010 Horde St. Wheaton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 29, 1961</b> to <b>Nov 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 29, 1961</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Blaine H. Eig</b>		22b. DATE SIGNED <b>Nov 30, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>BLAINE H. EIG</b>		22d. ADDRESS <b>2641 Colver Rd. Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-1-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hyattsville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>B Wanzanysky</b>		25a. REC'D BY REGISTRAR <b>DEC 4 '61</b>	
ADDRESS <b>3501-14 St. N. W.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



(M)

(K)

1275

Montgomery

Bethesda

Essex

Joseph

White

Male

Resident-Carpenter

John Birman

D.O.

Washington

1903 Minnesota Ave., S.E.

Birman

November 30, 1961

VI

May 12, 1960

USA

Resident

System 1000

Jack Birman, 11010 Fort St., Detroit, MI.

12-1-61 Mr. Robert O'Connor, Detroit, Michigan

## CERTIFICATE OF DEATH

Reg. Dist. No. 12744

12757

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONT.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Nursing Home</b>				d. STREET ADDRESS <b>3204 Clay St.</b>			
3. NAME OF DECEASED (Type or print) <b>John M. Blackburn</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 10, 1887</b>	9. AGE (In years lost birthday) <b>74</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shovel Operator-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>		11. BIRTHPLACE (State or foreign country) <b>Danville, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Blackburn</b>				14. MOTHER'S MAIDEN NAME <b>Isabelle Doss</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>342-05-7687</b>			
17. INFORMANT <b>Pyatt Funeral Home, Pinckneyville, Illinois</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) <b>Diabetes mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>several yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/29/61</b> , 19 <b>61</b> , to <b>11/6/61</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>10/29/61</b> , 19 <b>61</b> , and that death occurred at <b>11 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald Nelson</b>				ADDRESS (Street, city or town, state) <b>10620 Ga. Ave Sil Spg, Md</b>			
PHYSICIAN'S NAME (Type) <b>Donald Nelson</b>				DATE SIGNED <b>11/6/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit-Burial 11/9/61</b>		22b. DATE THEREOF <b>11/9/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Duwoin, Illinois</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner B. Humphrey, Inc.</b>				24a. REC'D BY REGISTRAR <b>NOV 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

(M)

1973

CENTRAL ATOMIC DEPT.

1973

Montgomery  
Knoxington

County of Blount, Alabama

John W. Thompson  
March 10, 1987

Several Operators -  
David Anderson

State of Alabama

County of Blount, Alabama

County of Blount, Alabama

County of Blount, Alabama

County of Blount, Alabama

County of Blount, Alabama

County of Blount, Alabama

County of Blount, Alabama

County of Blount, Alabama

County of Blount, Alabama

County of Blount, Alabama

County of Blount, Alabama

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

12758

12745

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>07 Gaithersburg, Md.</b> d. STREET ADDRESS <b>1 205 Oakmont Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Laurette Hetzel Bouchard</b>		4. DATE OF DEATH Month <b>11</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/9/89</b>	
9. AGE (In years birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>26</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Iowa</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Hetzel</b>		14. MOTHER'S MAIDEN NAME <b>Alice Belle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>265-03-2319-B</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Chronic nephrosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic cardiovascular disease</b> <b>Chronic pyelonephritis</b> <b>Coronary heart failure</b> <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b> <b>10 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11/26</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1954</b> , 19 <b>54</b> , to <b>11/26</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/26</b> , 19 <b>61</b> , and that death occurred at <b>2:25 p.m.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>G. F. Meadors</b> M.D.		22b. DATE, SIGNED <b>11/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. F. Meadors</b>		22d. ADDRESS <b>Damascus, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/29/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 29 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>C. S. Thomas</b>			

M

1

Longevity

Only

11 days

11 days

Longevity General Hospital

205 Belmont Avenue

Female

White

11/10/33

73

11

11

Richard Gettel

White

205 Belmont Avenue

General Hospital

General Hospital, 205 Belmont Avenue, New York, N.Y.  
10012



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12759  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in 1b <b>31 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b>		b. COUNTY <b>DeLand</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>415 Clara Avenue</b>		d. STREET ADDRESS <b>415 Clara Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Amie Susan Branch</b>		First <b>Amie</b>		Middle <b>Susan</b>		Last <b>Branch</b>		4. DATE OF DEATH Month <b>November</b>		Day <b>2</b>		Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 20, 1895</b>		9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b>		Days <b>66</b>		IF UNDER 24 HRS. Hours <b>66</b>		Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>George Clements</b>		14. MOTHER'S MAIDEN NAME <b>Martha Gibbs</b>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>267-38-3884</b>		17. INFORMANT <b>The Medical Record</b>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> DUE TO <b>053.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Infarction</b> (c) <b>E. Coli Septicemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b> <b>4 days</b> <b>6 days</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epidermoid Carcinoma of Vagina</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>October 2, 1961</b> to <b>November 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>November 2, 1961</b> , and that death occurred <b>12:55 PM</b> from the causes and on the date stated above.																	
22a. SIGNATURE <b>J. Kent Trinkle</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/2/61</b>													
22c. PHYSICIAN'S NAME (Type) <b>J. Kent Trinkle, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 11/3/61</b>		23b. DATE THEREOF <b>11/3/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakdale Cemetery</b>		23d. LOCATION (City, town or county) <b>Volusia County, Florida</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											



History

Bedrooms

31 days

Beland

115 Clara Avenue

The Clinical Center, Bethesda 14, Md.

x

61 November 2

French

Basan

Ande

August 20, 1952

Female White

x

Leucocytes

None

Georgia

U.S.A.

George Clements

Martha Gibson

The National Record

387-38-5884 The Clinical Center, Bethesda 14, Maryland

7 hours

Cardiovascular collapse

4 days

Acute myocardial infarction

6 days

E. Coli Septicemia

x

Epithelioid Carcinoma of Vagina

October 2 of November 2 of

12:58PM

November 2 of

11/2/52

x

The Clinical Center, National Institutes of Health, Bethesda 14, Md.

J. Kent Franklin, M.D.

Colville County, Florida

Colville Cemetery

11/2/52

Robert A. Humphrey, M.D.

Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12760

12747

<b>PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN lb <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11209 Upton Drive</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>38 Kensington</b> d. STREET ADDRESS <b>1 11209 Upton Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>JAMES B. BREEDEN</b> First Middle Last <b>4. DATE OF DEATH</b> <b>Nov. 23, 19 61</b> Month Day Year			<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Mar. 12, 1889</b> <b>9. AGE</b> (In years last birthday) <b>72 yrs.</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Fireman - Retired</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Virginia</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U. S.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b>			<b>13. FATHER'S NAME</b> <b>Unknown</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>578-01-2949-A</b> <b>17. INFORMANT</b> <b>Wife</b> <b>Mamie L. Breeden</b> Address <b>Same as Item 2.</b>			<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MYOCARDITIS</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>-</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF PROSTATE WITH METASTASIS TO LUNGS AND BRAIN</b> INTERVAL BETWEEN ONSET AND DEATH: MONTHS <b>420.0</b> YEARS <b>10</b>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>-</b> <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19 61</b> Hour e.m. <b>-</b> p.m. <b>-</b> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>-</b> <b>20f. (City or town)</b> <b>-</b> (County) (State)			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5 - 10:45P</b> <b>to</b> <b>11-23, 1961</b> , that (I) (we) last saw the deceased alive on <b>11-21, 1961</b> , and that death occurred at <b>10:45P</b> M, from the causes and on the date stated above.			<b>22a. SIGNATURE</b> <b>JACK SCHUMACHER</b> M.D. <b>22b. PHYSICIAN'S NAME</b> (Type) <b>JACK SCHUMACHER, M.D.</b> <b>22c. ADDRESS</b> <b>GAITHERSBURG, MARYLAND</b> <b>22d. DATE SIGNED</b> <b>11/24/61</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>11-27-61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parklawn Cemetery</b> <b>23d. LOCATION</b> (City, town or county) <b>Rockville, Maryland</b> (State)			<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. PUMPHREY</b> <b>Bethesda, Md.</b> <b>25a. REC'D BY REGISTRAR</b> <b>NOV 30 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>William S. House</i>		

(M)

(1)

13710

13717

NOTED

NOTED

Kenyon

Kenyon

11300 Union Drive

11300 Union Drive

JAMES

JAMES

OV. 27

1987. 12. 12

72

Prison - 1972

Prison - 1972

Unknown

Unknown

370-01-0249-A

370-01-0249-A

CRIMINAL RECORDS

CRIMINAL RECORDS

ALL INFORMATION HEREIN IS UNCLASSIFIED

SECTION OF RECORDS WITH REFERENCE TO LUCAS AND DRAIN

11-27-01

Patricia A. Smith

Rockville, Maryland

ROBERT A. MINNERY

Rockville, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12761

12748

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1701 White Oak Dr. 27</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>Silver Spring</u>			
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Hall</u> Last <u>Brimacombe</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 31 - 76</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Moses Hall</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ropp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-8061</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart failure - Uraemia</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Marcel obesity</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 26, 1961</u> to <u>Nov 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 21, 1961</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Marion Barkhead</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 21, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Marion Barkhead</u>				22d. ADDRESS <u>9241 Col. Blvd. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> 8434 GEORGIA AVENUE				25a. REC'D BY REGISTRAR <u>Nov 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60





1975

15748

2004

1027-44-055

1. *Chrysomelidae* (beetles)  
 2. *Curculionidae* (beetles)

12. 10. 1951

11-12-44

2. Motion Bankhead

21-10-1941

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12762

12749

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b> c. LENGTH OF STAY IN 1b <b>3 MOS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11901 Georgia Avenue WHEATON NURSING HOME</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>WASHINGTON, D. C.</b> b. COUNTY <b>WASHINGTON, D. C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D. C.</b> d. STREET ADDRESS <b>5425 CONNECTICUT AVE. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) <b>GEORGE HAY BROWN</b>				<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>21</b> Year <b>1961</b>										
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										
<b>8. DATE OF BIRTH</b> <b>11/23/1871</b>		<b>9. AGE</b> (In years last birthday) <b>89</b> yrs.                 IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>										
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>SALES</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>SUMMERVILLE, ILL.</b>										
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>AMR.</b>				<b>13. FATHER'S NAME</b> <b>GEORGE HAY BROWN</b>										
<b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH SACCASKI</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>										
<b>16. SOCIAL SECURITY NO.</b> <b>?</b>		<b>17. INFORMANT</b> Address <b>Records at Nursing Home -- Same # 1</b>												
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="3"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <i>Pyelonephritis Chronic</i>  <b>(b)</b> <i>Prostatitis</i>  <b>(c)</b> <i>Exhaustion</i> </td> <td colspan="3" rowspan="2"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>    </td> </tr> <tr> <td colspan="3"> <b>CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.</b> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Pyelonephritis Chronic</i> <b>(b)</b> <i>Prostatitis</i> <b>(c)</b> <i>Exhaustion</i>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>  			<b>CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.</b>		
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Pyelonephritis Chronic</i> <b>(b)</b> <i>Prostatitis</i> <b>(c)</b> <i>Exhaustion</i>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>  											
<b>CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.</b>														
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>														
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)												
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>										
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>Aug 8 1961</i> <b>to</b> <i>Nov 21 1961</i> <b>that (I) (we) last saw the deceased alive on</b> <i>Nov 18 1961</i> <b>and that death occurred at</b> <i>9 PM</i> <b>from the causes and on the date stated above.</b>														
<b>22a. SIGNATURE</b> <i>Thomas C. Thompson</i> M.D.				<b>22b. DATE SIGNED</b> <b>NOV 21 1961</b>										
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Thomas C. Thompson</b>				<b>22d. ADDRESS</b> <b>2032 16th St., N.W.</b>										
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/25/1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Congressional Cemetery Washington, D.C.</b>										
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H. Hines Co. - 2901 14th St., N.W.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 24 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hines</i>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

*Epiphyas phyllaea*  
*Chlorophylla*  
*Chlorophylla*

*Epiphyas phyllaea*  
1891

*Epiphyas phyllaea*  
1891

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12763

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12750

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>6 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> <u>53</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens</u>				d. STREET ADDRESS <u>5 Magnolia Parkway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY ROSS YOUNG BROWN</u>				4. DATE OF DEATH <u>Nov. 11 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 8, 1876</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>DR. Wm. Proby Young</u>				14. MOTHER'S MAIDEN NAME <u>IDA PERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital records</u>		Address <u>Same as Item #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>CEREBRAL THROMBOSIS - MULT. SMALL</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 23 1961</u> to <u>Nov 11 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 4 1961</u> , and that death occurred at <u>3:15 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert T. Thibadeau</u>				22b. DATE SIGNED <u>Nov 11-61</u>			
22c. PHYSICIAN'S NAME (Type or print) <u>ROBERT T. THIBADEAU</u>				22d. ADDRESS <u>10609 CONCORD ST. KENSINGTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 14 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

12520

CERTIFICATE OF DEATH

12520

MARK ROSS BROWN JR

26



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12764

CERTIFICATE OF DEATH

Reg. Dist. No. 12751

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>				d. STREET ADDRESS <b>19808 Crosby Place</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Frieda</b> Middle <b>Brunk</b> Last <b>Brunk</b>				4. DATE OF DEATH <b>November 27, 1961</b> Year <b>19</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/4/86</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.		IF UNDER 24 HRS. Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gottlieb Meisner</b>				14. MOTHER'S MAIDEN NAME <b>Marie Apelt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>101-03-4686A</b>		INFORMANT <b>Herman G. Brunk</b>		Address <b>219 Green Street Alexandria, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>583X</b> DUE TO <b>Hepatic insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>10620 Co. Ave, Sil Spg, Md</b> DUE TO <b>11/27/61</b> (c) <b>11/26/61</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10620 Co. Ave, Sil Spg, Md</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/26/1961</b> to <b>11/27/1961</b> , that I last saw the deceased alive on <b>11/26/1961</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald Nelson</b>		M.D.		ADDRESS (Street, city or town, state) <b>10620 Co. Ave, Sil Spg, Md</b>		DATE SIGNED <b>11/27/61</b>	
PHYSICIAN'S NAME (Type) <b>Donald Nelson, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11/30/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Pk, Cem. Falls Church, Va.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		24a. REC'D BY REGISTRAR <b>NOV 30 '61</b> DATE <b>NOV 30 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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4551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12765

12752

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Texas</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownsville</u>		d. STREET ADDRESS <u>Qtr. 169, Ft. Brown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		80X-3	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Robert</u> <u>Stephen</u> <u>Burpo Jr.</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1, 1915</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Stephen Burpo</u>				14. MOTHER'S MAIDEN NAME <u>Louise B. Carr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>034 07 7311</u>		17. INFORMANT <u>WIFE: Dorothy A. Burpo, Same as #2</u>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA BRAIN</u> DUE TO <u>191.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>SQUAMOUS CELL CARCINOMA NECK</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>21 DAYS</u> <u>7 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>October 31, 1961</u> to <u>November 17, 1961</u> , that (X) (we) last saw the deceased alive on <u>November 17, 1961</u> , and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G.W. Taylor Jr.</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>November 17, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>G.W. TAYLOR JR., CAPTAIN MC USN</u>				22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>21 Nov 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> <u>R.A. Pumphrey, Bethesda, Md.</u>				ADDRESS <u>  </u>		25a. REC'D BY REGISTRAR <u>NOV 21 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kras</u>				25c. REGISTRAR'S SIGNATURE <u>  </u>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12753

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>10½ days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>W.</b> Last <b>Burrell</b>		4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/78</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>6</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Navy Architect</b>	
11. BIRTHPLACE (State or foreign country) <b>Sunberry, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Burrell</b>		14. MOTHER'S MAIDEN NAME <b>Sue Sadler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Margaret H. Burrell-Wife-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal shut down</b> <b>541.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac failure</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-operative - Perforating duodenal ulcer</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/26</b> 19 <b>61</b> , to <b>11/6</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/6</b> 19 <b>61</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter Atkinson</b>		22b. DATE SIGNED <b>11/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter Atkinson</b>		22d. ADDRESS <b>1835 Eye St. N. W., Wash. D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

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MONTGOMERY STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. Montgomery b. COUNTY Bethesda							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8504 Rayburn Rd				d. STREET ADDRESS 8504 Rayburn Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Howard Raymond Campbell				4. DATE OF DEATH November 8 19 61				5. SEX Male			
6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. AGE (In years last birthday) 59 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist				10b. KIND OF BUSINESS OR INDUSTRY Retired				11. BIRTHPLACE (State or foreign country) Falls River, Mass.			
13. FATHER'S NAME Clarence C. Campbell				14. MOTHER'S MAIDEN NAME Margaret Stewart				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> ?				16. SOCIAL SECURITY NO. ?				17. INFORMANT wife, Cornelia N. Campbell, Same #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contusion, severe, jaw & brain stem 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Blunt Trauma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Assumed that he fell in his room at home							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. - 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home			
20f. (City or town) Montg.				20g. (County) Md.				20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE Frank Brochart				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Frank Brochart				Address (Street, city, town, or county) 11/8/61				DATE SIGNED 11/8/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/10/1961				22c. NAME OF CEMETERY OR CREMATORY Rural Cemetery			
22d. LOCATION (City, town, or country) New Bedford, Mass.				22e. LOCATION (City, town, or country) Port Lincoln, Maryland				22f. LOCATION (City, town, or country) Prince Georges County, Md.			
23. FUNERAL DIRECTOR The S.H.Hines Co.- Washington, D.C.				24a. REC'D BY REGISTRAR 2901 14th St., N.W.				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12768

## CERTIFICATE OF DEATH

Items #13 & #17 - Film G301 - 11/27/61-mmb

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>St Marys</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN lb <u>9 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>			d. STREET ADDRESS <u>Rt. #1, Box 145-D</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Margaret Ellen Campbell</u>			4. DATE OF DEATH <u>November 9 19 61</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>September 24, 1907</u>		9. AGE (In years last birthday) <u>54 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>John J. Reynolds</u>			14. MOTHER'S MAIDEN NAME <u>Lola Shelton</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579 14 5382</u>		17. INFORMANT <u>Harless</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u> 008 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Advanced fibrosis of lungs</u> (a), stating the underlying cause last, (c) <u>Tuberculosis probably arrested</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>3-4 wks</u> <u>7-10 yrs</u> <u>10 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 1, 1961</u> to <u>November 9 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 9, 1961</u> , and that death occurred at <u>1:30 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Robert E. DeForest</u> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9 November 1961</u>
22c. PHYSICIAN'S NAME (Type) <u>ROBERT E. DEFOREST, LT MC USN</u>			22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	
23d. LOCATION (City, town or county)		23e. (State) <u>Arlington, Va.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. DeVol</u> ADDRESS <u>D.C.</u>			25a. REC'D BY REGISTRAR <u>NOV 15 '61</u>		
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

MEDICAL CERTIFICATION

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FOR STATE  
HEALTH DEPT.

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TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>12769</div> <div>12756</div> </div> </div> <div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>12769</div> <div>12756</div> </div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>12769</div> <div>12756</div> </div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in 1b <u>5 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8600 16th St. apt 1010</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 26</u> d. STREET ADDRESS <u>8600 16th St. apt 1010</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Edward Cannon</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>nov 19 1961</u> Month Day Year				<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>11-18-1893</u> <b>9. AGE</b> (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Det. M. Police</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>retired</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>DC</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>? Cannon</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> <b>16. SOCIAL SECURITY NO.</b> <input type="checkbox"/> <b>17. INFORMANT</b> <u>Mary A. Cannon (wife)</u> Address <u>Itum 2</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <input type="checkbox"/> (a), stating the underlying cause last. DUE TO (c) <input type="checkbox"/>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u> <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>11-19-61</u> Address (Street, city, town, or county)											
<b>ACTUAL SIGNATURE</b> <u>Frank J. Boeschant</u> M.D. <b>EXAMINER'S NAME</b> (Type) <u>FRANK J. BOESCHANT</u> <b>DATE SIGNED</b>											
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>11-22-61</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet</u>			
<b>22d. LOCATION</b> (City, town, or country) (State) <u>Washington DC</u>				<b>24a. REC'D BY REGISTRAR</b> <u>NOV 21 '61</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>William S. Kraus</u>			
<b>23. FUNERAL DIRECTOR</b> ADDRESS <u>Deaf Funeral Home 4812 H St NW</u>											

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## CERTIFICATE OF DEATH

Reg. Dist. No. 12757

1. PLACE OF DEATH o. COUNTY <u>Montg.</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>		c. LENGTH OF STAY IN 1b <u>1Yr 6Mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Marylander Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ASENATH</u> First Middle Last <u>CHADWICK</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 10-1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexandria.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Willard P. Graves</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Libby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>George A. Chadwick.Jr, Boyd. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>embolism</u> DUE TO (c) <u>arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>Jan 25</u> , 19 <u>49</u> , to <u>29 Nov</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>28 Nov</u> , 19 <u>61</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Dawsonsville Md.</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D.			
PHYSICIAN'S NAME (Type) <u>John G. Fawcett</u> <u>Dawsonsville Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-1-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Darnestown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1885

CERTIFICATE OF DEATH

1885

1A

DEATH

State of Massachusetts  
County of Suffolk  
City of Boston

Witness my hand and seal  
this 1st day of May 1885

12771

12758

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MD

74

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VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47 Bethesda</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Lila M. Chandler</i>				4. DATE OF DEATH Month Day Year <i>Nov. 11 1961</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 12 1883</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>talent ed writing. govt.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Iowa</i>			
11. BIRTHPLACE (State or foreign country) <i>Iowa</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>School teacher August W. Nelson</i>				14. MOTHER'S MAIDEN NAME <i>Christine Johnson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>no</i>			
17. INFORMANT <i>Louise Clark</i>				Address <i>Page 45 Above</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arterosclerotic Heart Disease</i> DUE TO (c) <i>Diabetes Mellitus</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>10 years</i> <i>10 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>GI Bleeding - possible Carcinoma Stomach</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>11/61</i> 19 <i>61</i> to <i>11-11</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>11/11</i> 19 <i>61</i> , and that death occurred at <i>4:30 PM</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>W H Kilian</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>W H KILIAN MD</i>				22d. ADDRESS <i>8218 Wisconsin Ave</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/14/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>				25a. REC'D BY REGISTRAR <i>NOV 14 '61</i>			
ADDRESS <i>Bethesda, Maryland</i>				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

12728

CERTIFICATE OF DEATH

12728

(M)

1878

(1)

Place of Birth: [illegible]  
Date of Birth: [illegible]  
Cause of Death: [illegible]  
Place of Death: [illegible]  
Date of Death: [illegible]  
Signature: [illegible]  
Official: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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12772

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12759

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <b>WASHINGTON, D. C.</b> b. COUNTY <b>47X-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS SANITARIUM</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HELEN LOUISE CHASE</b> Middle Last		4. DATE OF DEATH Month <b>NOVEMBER 5,</b> Day Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 7, 1906</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES CLERK LANSBURGH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DEPARTMENT STORE</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>AMBROSE L. CHASE</b>		14. MOTHER'S MAIDEN NAME <b>JULIA MILLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-54-9200</b>	
17. INFORMANT <b>MRS. MARGUERITE C. DUVALL</b>		Address <b>SILVER SPRING, MD. 9201 BLIGO CREEK PKWY.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF COLON</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 YR.</b> <b>18 MOS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAR 1961</b> to <b>NOV 5 1961</b> , that (I) (we) lost saw the deceased alive on <b>11/5 1961</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John H. Tuohy</b>		22b. DATE SIGNED <b>11/5/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. TUOHY, M.D.</b>		22d. ADDRESS <b>7720 WISCONSIN AVE BETHESDA 14, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>NOV. 8, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>SUITLAND, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>NOV 7 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12773											
12760											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BEL PRE NURSING HOME</u>						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>5437-CENN. AVE. N.W. 66X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>LORETTA</u> First Middle Last 4. DATE OF DEATH <u>Nov. 15 1961</u> Month Day Year						5. SEX <u>FEM.</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 30, 1891</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Riley S. Barber</u> 14. MOTHER'S MAIDEN NAME <u>Aedia B. Acherty</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mae L. Wagner</u> Address <u>Some 25 #2</u>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis and diabetes</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>Nov. 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov. 15, 1961</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Jerome J. Krick</u> 22c. PHYSICIAN'S NAME (Type) <u>Jerome J. Krick</u> 22d. ADDRESS <u>2800 QUEBEC ST. N.W. WASH. D.C.</u>						22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Nov. 18, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u> 23d. LOCATION (City, town or county) (State) <u>Wash, D.C.</u>						24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>Columbia Silver Spring Md.</u> 25. REC'D BY REGISTRAR <u>Nov 21 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Conrad L. Kraus</u>					



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11-10-1961 10:30 AM 12-10-1961  
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 12774  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

12761

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LeDeau Gardens</b>				d. STREET ADDRESS <b>10705 Maybrook Place</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Elizabeth CHAGGETT</b>				4. DATE OF DEATH Month Day Year <b>Nov 4 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/4/1870</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Benjamin White</b>				14. MOTHER'S MAIDEN NAME (Unknown) <b>Viers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mary M. Cuttle-daughter-same 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>290.0 Broncho-pneumonia</b> DUE TO (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Pernicious Anemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>48 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1961</b> to <b>Nov 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 3, 1961</b> , and that death occurred at <b>4:30 am</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert T. Thibadeau</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov 4 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT T. THIBADEAU</b>				22d. ADDRESS <b>10609 CONCORD ST. KENS. MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/6/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Epis. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kincaid</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12775

12762

<b>PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pittsburg City Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lewisdale</u> d. STREET ADDRESS <u>2111 Charleston Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Frank Arnold Coffin</u>		4. DATE OF DEATH <u>11 21 1961</u>		9. AGE (in years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-7-84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Book Editor</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Coffin</u>		14. MOTHER'S MAIDEN NAME <u>Emma Packard</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Old Record - wife - same address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of L Lung due to cause of Ca.</u> DUE TO (b) <u>Probable cerebral thrombosis</u> DUE TO (c) <u>Double heavy hair melanes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Double heavy hair melanes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Nov. 21</u>		20g. (County) <u>Nov. 21</u>		20h. (State) <u>Nov. 21</u>		20i. (City or town) <u>Nov. 21</u>		20j. (County) <u>Nov. 21</u>	
20k. (State) <u>Nov. 21</u>		20l. (City or town) <u>Nov. 21</u>		20m. (County) <u>Nov. 21</u>		20n. (State) <u>Nov. 21</u>		20o. (City or town) <u>Nov. 21</u>	
20p. (County) <u>Nov. 21</u>		20q. (State) <u>Nov. 21</u>		20r. (City or town) <u>Nov. 21</u>		20s. (County) <u>Nov. 21</u>		20t. (State) <u>Nov. 21</u>	
20u. (City or town) <u>Nov. 21</u>		20v. (County) <u>Nov. 21</u>		20w. (State) <u>Nov. 21</u>		20x. (City or town) <u>Nov. 21</u>		20y. (County) <u>Nov. 21</u>	
20z. (State) <u>Nov. 21</u>		20aa. (City or town) <u>Nov. 21</u>		20ab. (County) <u>Nov. 21</u>		20ac. (State) <u>Nov. 21</u>		20ad. (City or town) <u>Nov. 21</u>	
20ae. (County) <u>Nov. 21</u>		20af. (State) <u>Nov. 21</u>		20ag. (City or town) <u>Nov. 21</u>		20ah. (County) <u>Nov. 21</u>		20ai. (State) <u>Nov. 21</u>	
20aj. (City or town) <u>Nov. 21</u>		20ak. (County) <u>Nov. 21</u>		20al. (State) <u>Nov. 21</u>		20am. (City or town) <u>Nov. 21</u>		20an. (County) <u>Nov. 21</u>	
20ao. (State) <u>Nov. 21</u>		20ap. (City or town) <u>Nov. 21</u>		20aq. (County) <u>Nov. 21</u>		20ar. (State) <u>Nov. 21</u>		20as. (City or town) <u>Nov. 21</u>	
20at. (County) <u>Nov. 21</u>		20au. (State) <u>Nov. 21</u>		20av. (City or town) <u>Nov. 21</u>		20aw. (County) <u>Nov. 21</u>		20ax. (State) <u>Nov. 21</u>	
20ay. (City or town) <u>Nov. 21</u>		20az. (County) <u>Nov. 21</u>		20ba. (State) <u>Nov. 21</u>		20bb. (City or town) <u>Nov. 21</u>		20bc. (County) <u>Nov. 21</u>	
20bd. (State) <u>Nov. 21</u>		20be. (City or town) <u>Nov. 21</u>		20bf. (County) <u>Nov. 21</u>		20bg. (State) <u>Nov. 21</u>		20bh. (City or town) <u>Nov. 21</u>	
20bi. (County) <u>Nov. 21</u>		20bj. (State) <u>Nov. 21</u>		20bk. (City or town) <u>Nov. 21</u>		20bl. (County) <u>Nov. 21</u>		20bm. (State) <u>Nov. 21</u>	
20bn. (City or town) <u>Nov. 21</u>		20bo. (County) <u>Nov. 21</u>		20bp. (State) <u>Nov. 21</u>		20bq. (City or town) <u>Nov. 21</u>		20br. (County) <u>Nov. 21</u>	
20bs. (State) <u>Nov. 21</u>		20bt. (City or town) <u>Nov. 21</u>		20bu. (County) <u>Nov. 21</u>		20bv. (State) <u>Nov. 21</u>		20bw. (City or town) <u>Nov. 21</u>	
20bx. (County) <u>Nov. 21</u>		20by. (State) <u>Nov. 21</u>		20bz. (City or town) <u>Nov. 21</u>		20ca. (County) <u>Nov. 21</u>		20cb. (State) <u>Nov. 21</u>	
20cc. (City or town) <u>Nov. 21</u>		20cd. (County) <u>Nov. 21</u>		20ce. (State) <u>Nov. 21</u>		20cf. (City or town) <u>Nov. 21</u>		20cg. (County) <u>Nov. 21</u>	
20ch. (State) <u>Nov. 21</u>		20ci. (City or town) <u>Nov. 21</u>		20cj. (County) <u>Nov. 21</u>		20ck. (State) <u>Nov. 21</u>		20cl. (City or town) <u>Nov. 21</u>	
20cm. (County) <u>Nov. 21</u>		20cn. (State) <u>Nov. 21</u>		20co. (City or town) <u>Nov. 21</u>		20cp. (County) <u>Nov. 21</u>		20cq. (State) <u>Nov. 21</u>	
20cr. (City or town) <u>Nov. 21</u>		20cs. (County) <u>Nov. 21</u>		20ct. (State) <u>Nov. 21</u>		20cu. (City or town) <u>Nov. 21</u>		20cv. (County) <u>Nov. 21</u>	
20cw. (State) <u>Nov. 21</u>		20cx. (City or town) <u>Nov. 21</u>		20cy. (County) <u>Nov. 21</u>		20cz. (State) <u>Nov. 21</u>		20da. (City or town) <u>Nov. 21</u>	
20db. (County) <u>Nov. 21</u>		20dc. (State) <u>Nov. 21</u>		20dd. (City or town) <u>Nov. 21</u>		20de. (County) <u>Nov. 21</u>		20df. (State) <u>Nov. 21</u>	
20dg. (City or town) <u>Nov. 21</u>		20dh. (County) <u>Nov. 21</u>		20di. (State) <u>Nov. 21</u>		20dj. (City or town) <u>Nov. 21</u>		20dk. (County) <u>Nov. 21</u>	
20dl. (State) <u>Nov. 21</u>		20dm. (City or town) <u>Nov. 21</u>		20dn. (County) <u>Nov. 21</u>		20do. (State) <u>Nov. 21</u>		20dp. (City or town) <u>Nov. 21</u>	
20dq. (County) <u>Nov. 21</u>		20dr. (State) <u>Nov. 21</u>		20ds. (City or town) <u>Nov. 21</u>		20dt. (County) <u>Nov. 21</u>		20du. (State) <u>Nov. 21</u>	
20dv. (City or town) <u>Nov. 21</u>		20dw. (County) <u>Nov. 21</u>		20dx. (State) <u>Nov. 21</u>		20dy. (City or town) <u>Nov. 21</u>		20dz. (County) <u>Nov. 21</u>	
20ea. (State) <u>Nov. 21</u>		20eb. (City or town) <u>Nov. 21</u>		20ec. (County) <u>Nov. 21</u>		20ed. (State) <u>Nov. 21</u>		20ee. (City or town) <u>Nov. 21</u>	
20ef. (County) <u>Nov. 21</u>		20eg. (State) <u>Nov. 21</u>		20eh. (City or town) <u>Nov. 21</u>		20ei. (County) <u>Nov. 21</u>		20ej. (State) <u>Nov. 21</u>	
20ek. (City or town) <u>Nov. 21</u>		20el. (County) <u>Nov. 21</u>		20em. (State) <u>Nov. 21</u>		20en. (City or town) <u>Nov. 21</u>		20eo. (County) <u>Nov. 21</u>	
20eq. (State) <u>Nov. 21</u>		20er. (City or town) <u>Nov. 21</u>		20es. (County) <u>Nov. 21</u>		20et. (State) <u>Nov. 21</u>		20eu. (City or town) <u>Nov. 21</u>	
20ev. (County) <u>Nov. 21</u>		20ew. (State) <u>Nov. 21</u>		20ex. (City or town) <u>Nov. 21</u>		20ey. (County) <u>Nov. 21</u>		20ez. (State) <u>Nov. 21</u>	
20fa. (City or town) <u>Nov. 21</u>		20fb. (County) <u>Nov. 21</u>		20fc. (State) <u>Nov. 21</u>		20fd. (City or town) <u>Nov. 21</u>		20fe. (County) <u>Nov. 21</u>	
20fg. (State) <u>Nov. 21</u>		20fh. (City or town) <u>Nov. 21</u>		20fi. (County) <u>Nov. 21</u>		20fj. (State) <u>Nov. 21</u>		20fk. (City or town) <u>Nov. 21</u>	
20fl. (County) <u>Nov. 21</u>		20fm. (State) <u>Nov. 21</u>		20fn. (City or town) <u>Nov. 21</u>		20fo. (County) <u>Nov. 21</u>		20fp. (State) <u>Nov. 21</u>	
20fq. (City or town) <u>Nov. 21</u>		20fr. (County) <u>Nov. 21</u>		20fs. (State) <u>Nov. 21</u>		20ft. (City or town) <u>Nov. 21</u>		20fu. (County) <u>Nov. 21</u>	
20fv. (State) <u>Nov. 21</u>		20fw. (City or town) <u>Nov. 21</u>		20fx. (County) <u>Nov. 21</u>		20fy. (State) <u>Nov. 21</u>		20fz. (City or town) <u>Nov. 21</u>	
20ga. (County) <u>Nov. 21</u>		20gb. (State) <u>Nov. 21</u>		20gc. (City or town) <u>Nov. 21</u>		20gd. (County) <u>Nov. 21</u>		20ge. (State) <u>Nov. 21</u>	
20gf. (City or town) <u>Nov. 21</u>		20gg. (County) <u>Nov. 21</u>		20gh. (State) <u>Nov. 21</u>		20gi. (City or town) <u>Nov. 21</u>		20gj. (County) <u>Nov. 21</u>	
20gk. (State) <u>Nov. 21</u>		20gl. (City or town) <u>Nov. 21</u>		20gm. (County) <u>Nov. 21</u>		20gn. (State) <u>Nov. 21</u>		20go. (City or town) <u>Nov. 21</u>	
20gp. (County) <u>Nov. 21</u>		20gq. (State) <u>Nov. 21</u>		20gr. (City or town) <u>Nov. 21</u>		20gs. (County) <u>Nov. 21</u>		20gt. (State) <u>Nov. 21</u>	
20gu. (City or town) <u>Nov. 21</u>		20gv. (County) <u>Nov. 21</u>		20gw. (State) <u>Nov. 21</u>		20gx. (City or town) <u>Nov. 21</u>		20gy. (County) <u>Nov. 21</u>	
20gz. (State) <u>Nov. 21</u>		20ha. (City or town) <u>Nov. 21</u>		20hb. (County) <u>Nov. 21</u>		20hc. (State) <u>Nov. 21</u>		20hd. (City or town) <u>Nov. 21</u>	
20he. (County) <u>Nov. 21</u>		20hf. (State) <u>Nov. 21</u>		20hg. (City or town) <u>Nov. 21</u>		20hh. (County) <u>Nov. 21</u>		20hi. (State) <u>Nov. 21</u>	
20hj. (City or town) <u>Nov. 21</u>		20hk. (County) <u>Nov. 21</u>		20hl. (State) <u>Nov. 21</u>		20hm. (City or town) <u>Nov. 21</u>		20hn. (County) <u>Nov. 21</u>	
20ho. (State) <u>Nov. 21</u>		20hp. (City or town) <u>Nov. 21</u>		20hq. (County) <u>Nov. 21</u>		20hr. (State) <u>Nov. 21</u>		20hs. (City or town) <u>Nov. 21</u>	
20ht. (County) <u>Nov. 21</u>		20hu. (State) <u>Nov. 21</u>		20hv. (City or town) <u>Nov. 21</u>		20hw. (County) <u>Nov. 21</u>		20hx. (State) <u>Nov. 21</u>	
20hy. (City or town) <u>Nov. 21</u>		20hz. (County) <u>Nov. 21</u>		20ia. (State) <u>Nov. 21</u>		20ib. (City or town) <u>Nov. 21</u>		20ic. (County) <u>Nov. 21</u>	
20id. (State) <u>Nov. 21</u>		20ie. (City or town) <u>Nov. 21</u>		20if. (County) <u>Nov. 21</u>		20ig. (State) <u>Nov. 21</u>		20ih. (City or town) <u>Nov. 21</u>	
20ii. (County) <u>Nov. 21</u>		20ij. (State) <u>Nov. 21</u>		20ik. (City or town) <u>Nov. 21</u>		20il. (County) <u>Nov. 21</u>		20im. (State) <u>Nov. 21</u>	
20in. (City or town) <u>Nov. 21</u>		20io. (County) <u>Nov. 21</u>		20ip. (State) <u>Nov. 21</u>		20iq. (City or town) <u>Nov. 21</u>		20ir. (County) <u>Nov. 21</u>	
20is. (State) <u>Nov. 21</u>		20it. (City or town) <u>Nov. 21</u>		20iu. (County) <u>Nov. 21</u>		20iv. (State) <u>Nov. 21</u>		20iw. (City or town) <u>Nov. 21</u>	
20ix. (County) <u>Nov. 21</u>		20iy. (State) <u>Nov. 21</u>		20iz. (City or town) <u>Nov. 21</u>		20ja. (County) <u>Nov. 21</u>		20jb. (State) <u>Nov. 21</u>	
20jc. (City or town) <u>Nov. 21</u>		20jd. (County) <u>Nov. 21</u>		20je. (State) <u>Nov. 21</u>		20jf. (City or town) <u>Nov. 21</u>		20jg. (County) <u>Nov. 21</u>	
20jh. (State) <u>Nov. 21</u>		20ji. (City or town) <u>Nov. 21</u>		20jj. (County) <u>Nov. 21</u>		20jk. (State) <u>Nov. 21</u>		20jl. (City or town) <u>Nov. 21</u>	
20jm. (County) <u>Nov. 21</u>		20jn. (State) <u>Nov. 21</u>		20jo. (City or town) <u>Nov. 21</u>		20jp. (County) <u>Nov. 21</u>		20jq. (State) <u>Nov. 21</u>	
20jr. (City or town) <u>Nov. 21</u>		20js. (County) <u>Nov. 21</u>		20jt. (State) <u>Nov. 21</u>		20ju. (City or town) <u>Nov. 21</u>		20jv. (County) <u>Nov. 21</u>	
20jw. (State) <u>Nov. 21</u>		20jx. (City or town) <u>Nov. 21</u>		20jy. (County) <u>Nov. 21</u>		20jz. (State) <u>Nov. 21</u>		20ka. (City or town) <u>Nov. 21</u>	
20kb. (County) <u>Nov. 21</u>		20kc. (State) <u>Nov. 21</u>		20kd. (City or town) <u>Nov. 21</u>		20ke. (County) <u>Nov. 21</u>		20kf. (State) <u>Nov. 21</u>	
20kg. (City or town) <u>Nov. 21</u>		20kh. (County) <u>Nov. 21</u>		20ki. (State) <u>Nov. 21</u>		20kl. (City or town) <u>Nov. 21</u>		20km. (County) <u>Nov. 21</u>	
20kn. (State) <u>Nov. 21</u>		20ko. (City or town) <u>Nov. 21</u>		20kp. (County) <u>Nov. 21</u>		20kq. (State) <u>Nov. 21</u>		20kr. (City or town) <u>Nov. 21</u>	
20ks. (County) <u>Nov. 21</u>		20kt. (State) <u>Nov. 21</u>		20ku. (City or town) <u>Nov. 21</u>		20kv. (County) <u>Nov. 21</u>		20kw. (State) <u>Nov. 21</u>	
20kx. (City or town) <u>Nov. 21</u>		20ky. (County) <u>Nov. 21</u>		20kz. (State) <u>Nov. 21</u>		20la. (City or town) <u>Nov. 21</u>		20lb. (County) <u>Nov. 21</u>	
20lc. (State) <u>Nov. 21</u>		20ld. (City or town) <u>Nov. 21</u>		20le. (County) <u>Nov. 21</u>		20lf. (State) <u>Nov. 21</u>		20lg. (City or town) <u>Nov. 21</u>	
20lh. (County) <u>Nov. 21</u>		20li. (State) <u>Nov. 21</u>		20lj. (City or town) <u>Nov. 21</u>		20lk. (County) <u>Nov. 21</u>		20ll. (State) <u>Nov. 21</u>	
20lm. (City or town) <u>Nov. 21</u>		20ln. (County) <u>Nov. 21</u>		20lo. (State) <u>Nov. 21</u>		20lp. (City or town) <u>Nov. 21</u>		20lq. (County) <u>Nov. 21</u>	
20lr. (State) <u>Nov. 21</u>		20ls. (City or town) <u>Nov. 21</u>		20lt. (County) <u>Nov. 21</u>		20lu. (State) <u>Nov. 21</u>		20lv. (City or town) <u>Nov. 21</u>	
20lw. (County) <u>Nov. 21</u>		20lx. (State) <u>Nov. 21</u>		20ly. (City or town) <u>Nov. 21</u>		20lz. (County) <u>Nov. 21</u>		20ma. (State) <u>Nov. 21</u>	
20mb. (City or town) <u>Nov. 21</u>		20mc. (County) <u>Nov. 21</u>		20md. (State) <u>Nov. 21</u>		20me. (City or town) <u>Nov. 21</u>		20mf. (County) <u>Nov. 21</u>	
20mg. (State) <u>Nov. 21</u>		20mh. (City or town) <u>Nov. 21</u>		20mi. (County) <u>Nov. 21</u>		20mj. (State) <u>Nov. 21</u>		20mk. (City or town) <u>Nov. 21</u>	
20ml. (County) <u>Nov. 21</u>		20mn. (State) <u>Nov. 21</u>		20mo. (City or town) <u>Nov. 21</u>		20mp. (County) <u>Nov. 21</u>		20mq. (State) <u>Nov. 21</u>	
20mr. (City or town) <u>Nov. 21</u>		20ms. (County) <u>Nov. 21</u>		20mt. (State) <u>Nov. 21</u>		20mu. (City or town) <u>Nov. 21</u>		20mv. (County) <u>Nov. 21</u>	
20mw. (State) <u>Nov. 21</u>		20mx. (City or town) <u>Nov. 21</u>		20my. (County) <u>Nov. 21</u>		20mz. (State) <u>Nov. 21</u>		20na. (City or town) <u>Nov. 21</u>	
20nb. (County) <u>Nov. 21</u>		20nc. (State) <u>Nov. 21</u>		20nd. (City or town) <u>Nov. 21</u>		20ne. (County) <u>Nov. 21</u>		20nf. (State) <u>Nov. 21</u>	
20ng. (City or town) <u>Nov. 21</u>		20nh. (County) <u>Nov. 21</u>		20ni. (State) <u>Nov. 21</u>		20nj. (City or town) <u>Nov. 21</u>		20nk. (County) <u>Nov. 21</u>	
20nl. (State) <u>Nov. 21</u>		20nm. (City or town) <u>Nov. 21</u>		20no. (County) <u>Nov. 21</u>		20np. (State) <u>Nov. 21</u>		20nq. (City or town) <u>Nov. 21</u>	
20nr. (County) <u>Nov. 21</u>		20ns. (State) <u>Nov. 21</u>		20nt. (City or town) <u>Nov. 21</u>		20nu. (County) <u>Nov. 21</u>		20nv. (State) <u>Nov. 21</u>	
20nw. (City or town) <u>Nov. 21</u>		20nx. (County) <u>Nov. 21</u>		20ny. (State) <u>Nov. 21</u>		20nz. (City or town) <u>Nov. 21</u>		20oa. (County) <u>Nov. 21</u>	
20ob. (State) <u>Nov. 21</u>		20oc. (City or town) <u>Nov. 21</u>		20od. (County) <u>Nov. 21</u>		20oe. (State) <u>Nov. 21</u>		20of. (City or town) <u>Nov. 21</u>	
20og. (County) <u>Nov. 21</u>		20oh. (State) <u>Nov. 21</u>		20oi. (City or town) <u>Nov. 21</u>		20oj. (County) <u>Nov. 21</u>		20ok. (State) <u>Nov. 21</u>	
20ol. (City or town) <u>Nov. 21</u>		20om. (County) <u>Nov. 21</u>		20on. (State) <u>Nov. 21</u>		20oo. (City or town) <u>Nov. 21</u>		20op. (County) <u>Nov. 21</u>	
20oq. (State) <u>Nov. 21</u>		20or. (City or town) <u>Nov. 21</u>		20os. (County) <u>Nov. 21</u>		20ot. (State) <u>Nov. 21</u>		20ou. (City or town) <u>Nov. 21</u>	
20ov. (County) <u>Nov. 21</u>		20ow. (State) <u>Nov. 21</u>		20ox. (City or town) <u>Nov. 21</u>		20oy. (County) <u>Nov. 21</u>		20oz. (State) <u>Nov. 21</u>	
20pa. (City or town) <u>Nov. 21</u>		20pb. (County) <u>Nov. 21</u>		20pc. (State) <u>Nov. 21</u>		20pd. (City or town) <u></u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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MONTGOMERY  
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
12763

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>Dade</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Miami</u> <u>4 BX-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>9443 SW 36th St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennie June Colburn</u>		4. DATE OF DEATH Month Day Year <u>Nov 10 1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28 1869</u>
9. AGE (In years lost birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dressmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self emp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Washburn Cleveland</u>		14. MOTHER'S MAIDEN NAME <u>Anne Butterfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Catherine Atwood</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Splanchnic thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>20 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1941</u> to <u>Nov 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 19 1961</u> , and that death occurred at <u>9:30 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>A. D. Brigand</u>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>A. D. BRIGAND</u>		22d. ADDRESS <u>Sandy Springs, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>11-11-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lake Mill</u>		23d. LOCATION (City, town, or county) (State) <u>Lake Mills, Wisconsin</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>		24. ADDRESS <u>Laytonsville, Md.</u>	
25a. REC'D BY REGISTRAR <u>NOV 15 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

13776

CENTRAL BANK OF DENMARK

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212

WISCONSIN

James B. Bittorf  
Catharine Bittorf

Wardens Clerk

James B. Bittorf

Wardens Clerk

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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

Items 18&21 Film 301  
11-21-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12777

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12764

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ulnsey</u>		c. LENGTH OF STAY in 1b <u>D.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ulnsey</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elgas</u> <u>Copeland</u>		4. DATE OF DEATH <u>Nov 6 1961</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13, 1901</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Copeland</u>		14. MOTHER'S MAIDEN NAME <u>Martha</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Albert Murphy - Ulnsey, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis, moderately severe</u> 343X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Encephalitis, mild</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-7-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>Rockville, Md.</u>			
22a. BURIAL, CREMATION, REBURY (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/2/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion.</u>		22d. LOCATION (City, town, or country) (State) <u>Mt. Zion, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert R. Snowden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 15 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Rouse</u>	

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RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>	
c. LENGTH OF STAY IN 1b <b>16 Months</b>		d. STREET ADDRESS <b>9901 Connecticut Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Kensington Gardens Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>IRVIN</b> Last <b>COWARD</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1880</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Horace Irvin</b>		14. MOTHER'S MAIDEN NAME <b>Ella Jewel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Medical Record</b>		Address <b>Kensington Gard. Sanitarium</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anterolateral Heart Disease</b> DUE TO (c) <b>Severely (79 yr age)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>6 yrs.</b> <b>6 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1958</b> to <b>2 Nov. 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>10-15 1961</b> , and that death occurred at <b>7:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Samuel T. Herdell</b>		22b. DATE SIGNED <b>2 Nov. '61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>927 Parkside Drive, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>11-4-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's Sons, Inc. 1736-Palmer Ave.</b>		25a. REC'D BY REGISTRAR <b>NOV 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Crawford</u> Last <u>Crawford</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 8, 1873</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u>		11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>James C. Crawford</u>				14. MOTHER'S MAIDEN NAME <u>Kate Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mr. Edwin C. Blanchard</u>		Address <u>5410 Conn. Ave. N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>61</u> , to <u>Nov. 30</u> , 19 <u>61</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Nov 29</u> , 19 <u>61</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>DeWitt E. DeLawter</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>DeWITT E. DeLAWTER</u>				22d. ADDRESS <u>8025 ARLINGDALE RD. Bethesda 14 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Henry Co.</u>				25a. REC'D BY REGISTRAR <u>DEC 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Henry</u>	

1576

CENTRAL VA OF DEATH

1977

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MONTGOMERY MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12780 CERTIFICATE OF DEATH 12767											
1. PLACE OF DEATH a. COUNTY MONTGOMERY						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA						c. LENGTH OF STAY IN 1b 11 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN						d. STREET ADDRESS 10408 MONTROSE AVE.					
3. NAME OF DECEASED (Type or print) First Middle Last RALPH Whitney CREELE						4. DATE OF DEATH Month Day Year NOV 23 1961					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH 4-21-05		9. AGE (in years last birthday) 56 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman				10b. KIND OF BUSINESS OR INDUSTRY D.C		11. BIRTHPLACE (County & State, or foreign country) Wash. D.C				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLARENCE CREELE						14. MOTHER'S MAIDEN NAME ANNA H. SWART					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO						16. SOCIAL SECURITY NO. 579-50-3964		17. INFORMANT WIFE ELIXABETH SAME AS ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebral INFARCTION (c) Arteriosclerosis, generalized										INTERVAL BETWEEN ONSET AND DEATH 7-10d	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11/11, 1961, to 11/23, 1961, that (I) (we) last saw the deceased alive on 11/23, 1961, and that death occurred at 2:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE John B. Umhau						22b. DATE SIGNED Nov. 24/61					
22c. PHYSICIAN'S NAME (Type) JOHN UMHAU						22d. ADDRESS 8805 Penn Ave Ch. Ch 15 Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/27/61			23c. NAME OF CEMETERY OR CREMATORY Darnestown Presbyterian			23d. LOCATION (City, town or county) (State) Montgomery Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Ziska						25a. REC'D BY REGISTRAR NOV 27 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
25. REC'D BY REGISTRAR NOV 27 '61											

12780

12780



X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12781

12768

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Iowa</b> b. COUNTY <b>Exira</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>No street address</b> d. STREET ADDRESS <b>No street address</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Cecil Kenneth Cullings</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>November 11, 19 61</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>January 2, 1900</b>	<b>9. AGE</b> (In years last birthday) yrs. <b>61</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Banker</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Banking</b>		
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Iowa</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Phil Cullings</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Ida Parshall</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			<b>16. SOCIAL SECURITY NO.</b> <b>Unavailable</b>		
<b>17. INFORMANT</b> <b>The Medical Record</b>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable acute myocardial infarction</b> DUE TO (b) <b>Coronary Heart disease</b> DUE TO (c) <b>Diabetes Mellitus</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260X</b>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>7 1 hour</b> <b>7 years</b> <b>17 years</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>1. polycythemia rubra vera 2. Multiple myeloma</b>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <b>November 6, 19 61</b>		<b>20g. (County)</b> <b>November 11, 19 61</b>		<b>20h. (State)</b> <b>6:20AM</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 6, 19 61</b> to <b>November 11, 19 61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 11, 19 61</b> , and that death occurred at <b>6:20AM</b> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>Edward S. Henderson</b> M.D.			<b>22b. DATE SIGNED</b> <b>11/11/61</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Edward S. Henderson, M.D.</b>			<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial-transit 11-12-61</b>		<b>23b. DATE THEREOF</b> <b>11-12-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Exira Cemetery</b>	
<b>23d. LOCATION</b> (City, town or county) <b>Exira, Iowa</b>		<b>23e. (State)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. PUMPHREY</b>			<b>24b. ADDRESS</b> <b>Bethesda, Md.</b>		
<b>25a. REC'D BY REGISTRAR</b> <b>NOV 17 '61</b>			<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>		

12781

12781

M

Monography

Scientific

5 days

Latin

The Clinical Center, Bethesda II, Md. No street address

Good

Scientific

Outlines

November 11, 61

61

White

January 2, 1962

Banker

Banking

Low

U.S.A.

Anti outlines

Is favorable

Yes  
The Medical Record  
The Clinical Center, Bethesda II, Maryland

Probable acute myocardial infarction

1 year

Coronary heart disease

1 year

Diabetes mellitus

17 years

1. polycystic kidney disease  
2. Multiple myeloma

x

x

November 11, 61

November 6, 61

November 11, 61

11/11/61

The Clinical Center, National Institutes of Health, Bethesda II, Maryland

Extra, Iowa

Serial-transport 11-12-61 Extra Germany

ROBERT A. HUMPHREY  
Bethesda, Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12782

CERTIFICATE OF DEATH

Reg. Dist. No. 10769

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5 Chevy Chase, Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>13206 Rolling Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>W.</u> Last <u>Cushing</u>		4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/9/84</u>
9. AGE (In years lost birthday) yrs. <u>77</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louis T. Cushing</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rebecca Fabens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>George Butler Cushing/same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Bronchial and pulmonary carcinogenic metastasis</u> DUE TO <u>Prostatic carcinoma - left ureteral obstruction and left hydronephrosis</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>2 mos.</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - 10 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1951</u> , 19 <u>  </u> , to <u>Nov. 17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>November 17</u> , 19 <u>61</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edw. Krause</u> M.D.		ADDRESS (Street, city or town, state) <u>3805 McKinley St., N.W., Washington, D.C. (15)</u>	
PHYSICIAN'S NAME (Type) <u>Edward A. Krause, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/21/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 22 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Charles S. Krause</u>	

CERTIFICATE OF DEATH

1274

(M)

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 10 1900		BALTIMORE, MD		NATURAL	
AGE		SEX		RACE	
60		M		W	
BIRTH DATE		BIRTH PLACE		EDUCATION	
JAN 10 1840		BALTIMORE, MD		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		IMMEDIATE CAUSE	
DRUGGIST		HEART DISEASE		CORONARY THROMBOSIS	
PREVIOUS ILLNESS		PERIOD OF ILLNESS		TREATMENT	
NONE		2 WEEKS		NONE	
PREVIOUS SURGERY		DATE OF BURIAL		PLACE OF BURIAL	
NONE		JAN 12 1900		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
J. H. BROWN		J. H. BROWN		J. H. BROWN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1900		JAN 10 1900		JAN 10 1900	

RECEIVED

THE ATTORNEY GENERAL'S OFFICE



15873

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12784

## CERTIFICATE OF DEATH

12771

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>35</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>12103 Selfridge Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Agnes L. Day</u>				4. DATE OF DEATH Month Day Year <u>Nov. 29 19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 28, 1885</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Osala Salyards</u>				14. MOTHER'S MAIDEN NAME <u>Annie Good Salyards</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Daughter Virginia Blundon (Same as above)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>15 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-7-61</u> , to <u>11-29</u> , 19 <u>61</u> , that (I) <u>was</u> last saw the deceased alive on <u>11-29-61</u> , 19 <u>61</u> , and that death occurred at <u>1:58</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Morris Perry</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11-29-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Morris Perry</u>				22d. ADDRESS <u>11602 Georgia Ave. Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Luth. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>New Market, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Lee + Son</u> ADDRESS <u>300-4th NE Wash DC</u>				25a. REC'D BY REGISTRAR <u>DEC 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Clairmont E. Haines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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 12785  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 12772

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville 16 days</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>12100 - Dexter Ave. 101</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martin Alfred DeBroske</u>				4. DATE OF DEATH Month Day Year <u>Nov. 8 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/27/88</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoes.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael L. DeBroske</u>				14. MOTHER'S MAIDEN NAME <u>? UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-03-3453A</u>		17. INFORMANT <u>Eva C. DeBroske</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>356.1 Amyotrophic Lateral Sclerosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>10-31</u> 19 <u>61</u> , to <u>11-8-61</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11-8-61</u> 19 <u>61</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Morris Perry</u>				22b. ADDRESS <u>11602 Georgia Ave Silver Spring, Md.</u>		22c. PHYSICIAN'S NAME (Type) <u>MORRIS PERRY</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/11/61</u>		23c. NAME OF GEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE'S COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Warner</u> ADDRESS <u>6454 GEORGIA AVENUE</u> <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>NOV 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

15383

OFFICE OF DEATH

15383

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FOR STATE  
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

<div> <div> <div>12786</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>127773</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> </div>																													
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Kensington</u> d. STREET ADDRESS <u>3919 Decatur St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Stanley Albert</u>			<b>4. DATE OF DEATH</b> Last <u>Nov.</u> Month <u>28</u> Day <u>69</u> Year			<b>5. SEX</b> <u>Male</u>			<b>6. COLOR OR RACE</b> <u>White</u>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>Feb. 16, 1901</u>			<b>9. AGE</b> (In years last birthday) <u>60</u> yrs.			<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>			<b>11. IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer Custodian of Mont. Co. Schools</u>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Schools of Mont. Co.</u>						<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maine</u>						<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>											
<b>13. FATHER'S NAME</b> <u>Nathaniel</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Amelia Beetcher</u>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)						<b>16. SOCIAL SECURITY NO.</b> <u>XXXXXXXXXXXX</u>						<b>17. INFORMANT</b> <u>Stanley E. Densmore (Son) Hyattsville, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (e), stating the underlying cause last. (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>						<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of Injury in Part I or Part II of item 18.)																							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. <u>19</u> p.m.						<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town)</b>			<b>(County)</b>			<b>(State)</b>											
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
<b>ACTUAL SIGNATURE</b> <u>James J. Brochart</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>11.29.61</u>																	
<b>EXAMINER'S NAME</b> (Type) <u>Frank J. Brochart</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>																	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>						<b>22b. DATE THEREOF</b> <u>12/2/61</u>			<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Oakdale Cemetery</u>			<b>22d. LOCATION</b> (City, town, or country) <u>Middleton, Mass.</u>			<b>(State)</b>														
<b>23. FUNERAL DIRECTOR</b> <u>Raymond A. Ziska</u>						<b>ADDRESS</b> <u>8434 GEORGIA AVENUE</u>						<b>24a. REC'D BY REGISTRAR</b> <u>NOV 30 '61</u>			<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Fenne</u>														
<b>WARNER E. PUMPHREY, INC.</b>						<b>SILVER SPRING, MARYLAND</b>																							

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12787

## CERTIFICATE OF DEATH

12774

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Resmor Sanitarium &amp; Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Wash. D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2910-Tennyson St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Clara E Douglas</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>19 61</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7/30/1873</b>		9. AGE (In years last birthday) <b>88</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Casey</b>			14. MOTHER'S MAIDEN NAME <b>Mary Vermillion</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. Frank J. Wilson, 2910 Tennyson St. NW Wash, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral artery thrombosis Rt</b> 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>10 days</b> <b>2 yrs</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 4</b> 19 <b>59</b> to <b>Nov 3</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Nov 3</b> 19 <b>61</b> , and that death occurred at <b>11:35 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>James J. Foster</b>			22b. DATE SIGNED <b>11/4/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>JAMES J. FOSTER</b>			22d. ADDRESS <b>1746 K St N.W. Wash. D.C.</b>		
23a. BURIAL, CREMATION <b>burial</b>		23b. DATE THEREOF <b>11/6/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	
23d. LOCATION (City, town or county) <b>Washington, D.C.</b>		23e. REC'D BY REGISTRAR <b>NOV 6 '61</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W.</b>			25. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

Mary Vermillion  
 2910 Tennessee St., N.W.  
 Washington, D.C.  
 1878

Female  
 White  
 68  
 U.S.A.

Mary Vermillion  
 2910 Tennessee St., N.W.  
 Washington, D.C.  
 1878

Mary Vermillion  
 2910 Tennessee St., N.W.  
 Washington, D.C.  
 1878

Mary Vermillion  
 2910 Tennessee St., N.W.  
 Washington, D.C.  
 1878

Mary Vermillion  
 2910 Tennessee St., N.W.  
 Washington, D.C.  
 1878



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12788  
MONTGOMERY  
12775  
MONTGOMERY

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		d. STREET ADDRESS <u>604 N. Harner Lane</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen Cornelia Duffin</u> First Middle Last		4. DATE OF DEATH <u>11</u> Month <u>23</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1897</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick M. Howard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-14-0653</u>	
17. INFORMANT <u>Evelyn Mackey, daughter, same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, acute, recurrent</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic C-V Disease</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u> <u>15-20 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, duration 20 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-12-1961</u> to <u>11-23-1961</u> , that (I) (we) last saw the deceased alive on <u>11-22-1961</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Clive E. Jackson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CLIVE E. JACKSON</u>		22d. ADDRESS <u>202 Martin Ln., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/26/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden -</u>		ADDRESS <u>Rockville, Md.</u>	
25a. REC'D BY REGISTRAR <u>NOV 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Haines</u>	

13788



*[Faint, mostly illegible handwritten text, likely containing personal details and medical history.]*

*[Faint handwritten text, possibly a signature or date.]*

*[Faint, mostly illegible handwritten text at the bottom of the page, possibly a signature or official statement.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12789					12776						
PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
MONTGOMERY		OLNEY			2 days		RT. #1 Box 251		UNK		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)											
Montgomery General Hospital											
3. NAME OF DECEASED					4. DATE OF DEATH						
First		Middle		Last		Month		Day		Year	
HOWARD		COLLIER		DUVALL		11-		22		19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		negro		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5-23-1896		65 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country)	
										Maryland	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					12. CITIZEN OF WHAT COUNTRY?	
Lott Duvall					Nora Warfield					U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT	
unk										hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										5 days	
541.1 DUE TO										5 days	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED	
Hour e.m. p.m. 19										While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/22/61 to 11/23/61, that (I) (we) last saw the deceased alive on 11/22/61, and that death occurred 3:00 PM, from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
O.H. Ligan										11/23/61	
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	
O.H. Ligan										Sandy Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF	
Burial										11/27/61	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)	
Emory Grove.,										Emory Grove, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE										25a. REC'D BY REGISTRAR	
Robert L. Suowden										25b. REGISTRAR'S SIGNATURE	
ADDRESS Rockville, Md.										DATE NOV 29 '61	
										Arthur L. Kline	

VR A15 (4)  
15M 9/60

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hospital records

*Handwritten notes:*  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12790  
12777  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Wheaton		d. STREET ADDRESS 10817 Georgia Avenue, Apt. T-1		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 10817 Georgia Avenue, Apt. T-1		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Judy O'Keefe Eamelli				4. DATE OF DEATH Month Day Year November 20 19 61							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1928		9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David Sherman Younce				14. MOTHER'S MAIDEN NAME Irabelle Devoard							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 222-18-4493		17. INFORMANT The Medical Record Address Not available The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 Septicemia DUE TO (b) Acute myelogenous leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 hours 7 weeks										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		20g. (County) Montgomery		20h. (State) Maryland	
21. I certify that (X) (this hospital) attended the deceased from 11 Nov 1961 to 20 Nov 1961, that (X) (we) last saw the deceased alive on 20 Nov 1961, and that death occurred at 9:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Edward S. Henderson M.D.				22b. DATE SIGNED Nov. 21, 1961							
22c. PHYSICIAN'S NAME (Type) EDWARD S. HENDERSON, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/24/61		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City, town or county) Montgomery Maryland		23e. LOCATION (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska WARNER E. PUMPHREY INC. SILVER SPRING, MARYLAND				24a. ADDRESS 8434 GEORGIA AVENUE		25a. REC'D BY REGISTRAR DATE NOV 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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The Clinical Center, Bethesda, Md.

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Institute of Health, Bethesda, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Use 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12791

## CERTIFICATE OF DEATH

12778

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Hall Sanitarium</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Gloucester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gloucester</b> d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNIE Lee</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1874</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months <b>XXXX</b> Days <b>XXXX</b> Hours <b>XXXX</b> Min. <b>XXXX</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Claiborn T. Roane</b>		14. MOTHER'S MAIDEN NAME <b>Ann E. Medlicott</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Sanitarium records</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X HYPERTENSIVE HEART DISEASE</b> DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>ESSENTIAL HYPERTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>					INTERVAL BETWEEN ONSET AND DEATH <b>-----</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>SENILITY</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>CHERRY CHASE, MD</b>	
20f. (City or town) <b>Gloucester</b>		20g. (County) <b>Gloucester</b>		20h. (State) <b>Virginia</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 31, 1960</b> , to <b>NOV 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>NOV 8, 1961</b> , and that death occurred at <b>10:35 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Henry M. Lowden</b>		22b. DATE SIGNED <b>11/8/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Henry M. Lowden</b>	
22d. ADDRESS <b>5206 NORWAY DR. CHERRY CHASE, MD</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gloucester Point Cem. Gloucester, Virginia</b>	
23d. LOCATION (City, town or county) <b>Gloucester</b>		23e. (State) <b>Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 10 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	



12701

12701

Montgomery

Virginia

Gloucester

Washington

Gloucester

Carroll Hall Sanitation

None

127

Female White

Nov. 25, 1934 60

Abundant

Housewife

Virginia

USA

Chairman T. Roane

Ann E. Medlicott

Sanitation records

None

no

Henry H. Lowden

Robert A. Pughrey, Bethesda, Maryland  
Gloucester Point Cem. Gloucester, Virginia  
11/10/51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death, and that the death certificate be retained by the hospital or attending physician. The law requires that the death certificate be executed, within 24 hours after death, and that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12792 CERTIFICATE OF DEATH 12779													
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN lb <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING RT. 2</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>CLARENCE BENJAMIN EDWARDS</b>			4. DATE OF DEATH <b>NOVEMBER 4 1961</b>			5. SEX <b>MALE</b>			6. COLOR OR RACE <b>WHITE</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH <b>2-4-1909</b>			9. AGE (In years last birthday) <b>52</b> yrs.			10. IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>HENRY EDWARDS</b>						14. MOTHER'S MAIDEN NAME <b>ARIANA GREENFIELD</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-</b>						16. SOCIAL SECURITY NO. <b>-</b>							
17. INFORMANT <b>HOSPITAL RECORDS</b>						Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BROUCHED PNEUMONIA BILATERAL</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>CIRRHOSIS OF LIVER</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>			20f. (City or town) (County) (State) <b>10-30-1961 to 11-4-1961</b>				
21. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>10-30-1961</b> to <b>11-4-1961</b> , that (I) <del>xxx</del> last saw the deceased alive on <b>11-4-1961</b> , and that death occurred at <b>10:25 AM</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Ad Broyard</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <b>CHARLES H. LIGON, M.D.</b>						22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried Nov 9-1961</b>			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Burtonsville - Md</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Talbot</b> ADDRESS <b>257 Carroll St</b>						25a. READ BY REGISTRAR <b>NOV 8 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>				

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SILVER SPRING ST. 2

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WHITE

HALE

UNION LODGE, ARMY

ALYING

HENRY EDWARDS

ALYING HOSPITAL

HOSPITAL RECORDS

RECEIVED  
JAN 1 1909

ALYING HOSPITAL

CHURCH, N. Y.

*Handwritten signatures and notes at the bottom of the page.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
12793					12780									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)									
a. COUNTY <b>Montgomery</b>					a. STATE <b>District of Columbia</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					b. COUNTY <b>Washington</b>									
c. LENGTH OF STAY IN 1b <b>19 days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md</b>					d. STREET ADDRESS <b>3740 McKinley Street, N.W.</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last <b>Mary Elizabeth Eldridge</b>					Month Day Year <b>November 12 1961</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 August 1954</b>		9. AGE (In years last birthday) yrs. <b>7</b>						
								IF UNDER 1 YEAR Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					11. BIRTHPLACE (County & State, or foreign country) <b>District of Columbia</b>				
										12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Lynn E. Eldridge</b>					14. MOTHER'S MAIDEN NAME <b>Alzore Elizabeth Hale</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Embryoma of Kidney</b>										<b>2 years</b>				
180X DUE TO														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
<b>Septicemia</b>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 24</b> 19 <b>61</b> to <b>Nov. 12</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>Nov. 12</b> 19 <b>61</b> , and that death occurred at <b>5:30PM</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Geo. H. Porter, III</b>										22b. DATE SIGNED <b>Nov. 12, 1961</b>				
22c. PHYSICIAN'S NAME (Type) <b>GEORGE H. PORTER, III, M.D.</b>										22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>										23b. DATE THEREOF <b>11-15-1961</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Meredith, New Hampshire</b>										23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Sawyers, Jr., Inc.</b>										25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>				
ADDRESS <b>1756 P St NW</b>										25b. REGISTRAR'S SIGNATURE <b>William S. Kinnel</b>				



12730

12731

(M)

Department of Health and Human Services

Washington, D.C. 20492

The Clinical Center, Bethesda, Md., 20892

November 12, 1961

27 August 1961

U.S.A.

Division of Clinical Research

The Clinical Center, Bethesda, Md., 20892

Nov. 12, 1961

5:30 PM

George H. Porter, III, M.D.  
The Clinical Center, National Institutes  
of Health, Bethesda, Md., Maryland

Removal, 11-15-1961

Nov. 12, 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

VR A15 (4)  
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12794 CERTIFICATE OF DEATH 12781

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>New Jersey</b> f. COUNTY <b>Iselin</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Iselin</b> d. STREET ADDRESS <b>129 Worth Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Deborah</b> First <b>-</b> Middle <b>Enden</b> Last		4. DATE OF DEATH <b>November 21</b> Month <b>19 61</b> Year				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 December 1957</b>	9. AGE (In years last birthday) <b>3 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frederick Enden</b>		14. MOTHER'S MAIDEN NAME <b>Helen Eisenberger</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Overwhelming Septicemia with congestive heart failure and Cardio Vascular Accident</b> DUE TO (b) <b>Post-operative Tetralogy de Fallot with Prosthetic Blalock Shunt Anastomosis</b> DUE TO (c) <b>Congenital Heart Disease - Tetralogy de Fallot</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 5, 1961</b> , to <b>November 21, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 21, 1961</b> , and that death occurred at <b>9:32 AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Allan Goldblatt</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Allan Goldblatt, M.D.</b>		22b. DATE SIGNED <b>November 21, 1961</b> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-22-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW YORK</b>		23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS</b>		ADDRESS <b>3501 14th St. NW</b>		25a. REC'D BY REGISTRAR <b>NOV 24 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12795

12782

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>19 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Bay Harbor Island, Miami Beach</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>9601 West Broadview Drive</b> d. STREET ADDRESS <b>9601 West Broadview Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <b>Solomon (None) Engel</b>				4. DATE OF DEATH Month Day Year <b>November 4, 19 61</b>															
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 11, 1913</b>		9. AGE (In years last birthday) <b>48 yrs.</b>		IF UNDER 1 YEAR Months Days <b>48</b>		IF UNDER 24 HRS. Hours Min. <b>48</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Philip Engel</b>				14. MOTHER'S MAIDEN NAME <b>Paula Rosenthal</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>				17. INFORMANT Address <b>The Medical Records The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple myeloma</b> <b>203 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>October 16, 1961 to November 4, 1961</b>		(County) <b>11/5/61</b>		(State) <b>11/5/61</b>							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 16, 1961</b> to <b>November 4, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 4, 1961</b> , and that death occurred at <b>8:50 PM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Robert H. Levin</b>				M.D. <b>Robert H. Levin, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>11/5/61</b>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <b>Robert H. Levin, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>				22e. RECORD BY REGISTRAR <b>NOV 7 61</b>				22f. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				23b. DATE THEREOF <b>Nov 5, 1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Beth David</b>				23d. LOCATION (City, town or county) (State) <b>Elmont, New York</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sol. Levinson &amp; Bros. Inc.</b>				ADDRESS <b>6010 Reist Road</b>				25a. RECORD BY REGISTRAR <b>NOV 7 61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>							

VR A15 (4)  
15M 9/60

18782

18782

(M)

Homecoming

Forwards

12 days

Bay Harbor Island, Island Beach

The Clinical Center, Bethesda, Md.

2001 West Broadway, New York

Solo (one)

Angel

November 11

October 11, 1912

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Male

Unlabeled

Communication

Form

U.S.A.

Philip Insel

Philip Insel

The Clinical Center

Unlabeled the Clinical Center, Bethesda, Md.

12 months

Philip Insel

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November 11

October 11, 1912

November 11

11/11/12

The Clinical Center, National

Institutes of Health, Bethesda, Md.

Robert H. Levin, M.D.

Removal

Nov 1, 1961

Bob Levin

Elmont, New York

Bob. Levinson & Bros. Inc. 6010 Reister Road

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
12796

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12783

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>58 Glen Echo</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>107 Harvard Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lydia</b> Middle <b>E</b> Last <b>Fagan</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1900</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Wear</b>		14. MOTHER'S MAIDEN NAME <b>Emma Wood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Jane Carter-daughter</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>coronary occlusion</b> DUE TO (c) <b>coronary arterio-sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>3 hrs.</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1959</b> to <b>11-10</b> , 1961, that (I) (we) last saw the deceased alive on <b>11-10</b> , 1961, and that death occurred at <b>4:48</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>R. M. Tilley, Jr.</b>		22b. DATE SIGNED <b>11-10-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. M. Tilley</b>		22d. ADDRESS <b>4701-Mass. Ave. N.W. Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/13/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 13 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

M

12598

CERTIFICATE OF DEATH

12598

John Brown  
100 Broadway Street  
New York City

John Brown  
100 Broadway Street  
New York City

Female  
White  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12797

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		d. STREET ADDRESS <b>10119 Crestwood Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert E.</b> Middle <b>Fellers</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 24, 1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Government employee</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>John D. Fellers</b>		14. MOTHER'S NAME <b>Katie E. Richard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>10+ yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>June 1959</b> to <b>Nov. 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>11/3</b> 1961, and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. H. Aschenbach</b>		22b. DATE SIGNED <b>11/5/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. H. Aschenbach</b>		22d. ADDRESS <b>1841 Col. Rd., N.W. Wash., D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11-8-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

M

CERTIFICATE OF DEATH

12387

12387

1. Name of deceased: *John D. Miller*  
2. Date of death: *January 11, 1900*  
3. Place of death: *Home, New York*  
4. Cause of death: *Heart failure*  
5. Age at death: *65 years*  
6. Sex: *Male*  
7. Race: *White*  
8. Occupation: *Teacher*  
9. Signature of physician: *John D. Miller*  
10. Signature of registrar: *John D. Miller*  
11. Date of registration: *January 11, 1900*  
12. Place of registration: *New York*

12798

12785

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>130 thesd 2</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>58 Washington, 16, D.C.</i>	
c. LENGTH OF STAY IN 1b <i>1 hr. 5 min.</i>		d. STREET ADDRESS <i>6304 - Mads Ave. N.W.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Stu burban.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Richard</i> Middle <i>Francis</i> Last <i>Field</i>		4. DATE OF DEATH Month <i>November</i> Day <i>7</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 15, 1896</i>
9. AGE (In years last birthday) <i>64</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>drug stores</i>	
11. BIRTHPLACE (State or foreign country) <i>New Hampshire</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John F. Field</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Sullivan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>51807-6783</i>	
17. INFORMANT <i>daughter</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Myocardial Infarction</i> DUE TO <i>42011</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Occlusion</i> DUE TO <i>Coronary artery sclerosis</i> (c) <i>5 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>9 a.m.</i> 19 <i>61</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1976</i> to <i>7 Nov</i> , 1961, that (I) (we) last saw the deceased alive on <i>6 Nov</i> , 1961, and that death occurred at <i>7:15 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Merton L. White</i>		22b. DATE SIGNED <i>Nov 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Merton L. White</i>		22d. ADDRESS <i>11134 Georgia Ave Silver Spring Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/10/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Silver Spring, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>NOV 10 61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hayes</i>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12753

CERTIFICATE OF DEATH

12753



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document.]*

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document.]*

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 12799  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

12786

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>3 hours</u>				d. STREET ADDRESS <u>6300 Tuba Lane</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Girl</u> Last <u>Finch</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 3, 1961</u>	
9. AGE (In years lost birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>30</u>		11. IF UNDER 24 HRS. Hours <u>3</u> Min. <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Rogers B. Finch</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Hine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Father</u>				Address <u>Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>				20f. (City or town) (County) (State) <u>—</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>61</u> , to <u>11/3</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> , 19 <u>61</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Ira W. Pearlman</u> M.D.				22b. DATE SIGNED <u>—</u>			
22c. PHYSICIAN'S NAME (Type) <u>IRA. W. PEARLMAN, M.D.</u>				22d. ADDRESS <u>4700 BRADLEY BLD., CHEVY CHASE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>11-4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>		23d. LOCATION (City, town, or county) (State) <u>BETHESDA, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Amelia Carter, Admin. per (OB)</u>				25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>	
ADDRESS <u>OLD GEORGETOWN, BETHESDA, MD.</u>				DATE <u>NOV 7 '61</u>			

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(M)

1873

CERTIFICATE OF DEATH

1873

*[Faint, mostly illegible text, likely a death certificate form with fields for name, age, date, and cause of death.]*



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FOR STATE  
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12800  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12787

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mmg</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>5 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3515 Glenmoor Rd</u>				d. STREET ADDRESS <u>3515 Glenmoor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frederick Coleman Fishback</u>				4. DATE OF DEATH <u>NOV 24 1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-7-98</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DR.</u>		11. BIRTHPLACE (State or foreign country) <u>DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick L. Fishback</u>				14. MOTHER'S MAIDEN NAME <u>Mable Coleman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, no, or unknown)</u>		16. SOCIAL SECURITY NO. <u>(If give giver or dates of service)</u>		17. INFORMANT <u>Kathleen Fishback - Sister</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450 J</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>11-24-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>11/25/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
22d. LOCATION (City, town, or country) <u>Prince Georges Md.</u>				22e. (State)			
23. FUNERAL DIRECTOR <u>Joseph Gawler's Sons</u>				ADDRESS <u>1756 Pa. Ave. N.W. Wash. D. C.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>							

Joseph Gember's Sons, Inc. 1758 E. Ave. N.W.  
Garden City, N.Y. 11530  
Prince Georges, Md.

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12801

12788

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany Co</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LaVale</u> d. STREET ADDRESS <u>47 LaVale Blvd.</u> e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Allan</u> Middle <u>Carol</u> Last <u>Fisher, SR.</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>28</u> Year <u>1961</u>															
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 29, 1885</u>		<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>IF UNDER 24 HRS.</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>District Car Distributor Western Maryland &amp; R.</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Pennsylvania</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>David Fisher</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Rachel Cessna</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>Yes</u>				<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>				<b>17. INFORMANT</b> <u>Washington Sanitarium and Hospital Records</u> Address <u>  </u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis, General</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> stating the underlying cause last. (c) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>9 days</u> <u>15 years</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11-19-61</u> Hour a.m. <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>							
<b>21. I certify that (I) (the hospital) attended the deceased from <u>11-19-61</u> to <u>Nov 28</u>, 19<u>61</u> that (I) (we) last saw the deceased alive on <u>Nov 27</u>, 19<u>61</u>, and that death occurred at <u>5:20 AM</u> from the causes and on the date stated above.</b>																			
<b>22a. SIGNATURE</b> <u>George B. Patrick Jr.</u>				<b>22b. DATE SIGNED</b> <u>11-28-61</u>				<b>22c. PHYSICIAN'S NAME</b> (Type) <u>George B. Patrick, Jr. MD</u>				<b>22d. ADDRESS</b> <u>9221 Colesville, Silver Spring, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Bur-Transit</u>				<b>23b. DATE THEREOF</b> <u>12/1/61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sunset Mem. Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) <u>Cumberland, Maryland</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey,</u>				<b>ADDRESS</b> <u>Bethesda, Maryland</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DEC 1 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Hanna</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>20 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4603 HARLING LANE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>50 BETHESDA</b> d. STREET ADDRESS <b>4603 HARLING LANE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JENNIE E. FOGG</b>		4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 9, 1871</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <b>89</b> yrs.
10. FATHER'S NAME <b>THOMAS DUNK</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CAMPBELLFORD, ONTARIO CANADA</b>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		13. SOCIAL SECURITY NO.	
14. INFORMANT DAUGHTER <b>BERNADINE GONDON</b>		15. ADDRESS <b>4603 HARLING LANE BETHESDA MD</b>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHIAL PNEUMONIA</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CEREBROVASCULAR ACCIDENT</b> (c) <b>ARTERIOSCLEROSIS, CEREBRAL &amp; GENERALIZED YEARS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 days.</b> <b>11 days.</b> <b>YEARS</b>			
17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
19. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>JUNE</b> , 19 <b>57</b> to <b>NOV 17</b> , 19 <b>61</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>NOV 15</b> , 19 <b>61</b> , and that death occurred at <b>9A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert N. Coale</b>		22b. DATE SIGNED <b>11/17/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>		22d. ADDRESS <b>4429 BRADLEY LANE, CHEVY CHASE MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		23b. DATE THEREOF <b>11-20-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Home Cemetery</b>		23d. LOCATION (City, town or county) <b>Forest Park, Illinois</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		24. ADDRESS <b>Bethesda, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William L. Evans</b>	





CERTIFICATE OF DEATH

Reg. Dist. No. 12790

1. PLACE OF DEATH a. COUNTY <u>1813 AUGUST DRIVE</u> <u>MONTGOMERY</u> <u>S.S.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1813 August Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>DESSIE</u> First <u>ELIZABETH</u> Middle <u>FRANK</u> Last		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William B. Bowie</u>		14. MOTHER'S MAIDEN NAME <u>CENIA A. DAVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, generalized</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, left breast—post operative</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, secondary, severe</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> , 19____, to <u>11-5-</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11-5-</u> , 19 <u>61</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL PHYSICIAN <u>Samuel A. Hillman</u> M.D. <u>8829 Flower Ave</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u> <u>SILVER SPRING, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>BURIAL</u>		<u>Nov 8, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>FORT LINCOLN</u>		<u>COLMAR MANOR, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Talbott</u>		ADDRESS <u>3603 14th St NW</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Wm S. Pines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Journal of the

WILLIAM A. JAMES

## CERTIFICATE OF DEATH

Reg. Dist. No. 12791

12804

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ednor</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Belmont Nursing Home</b>				d. STREET ADDRESS <b>None</b>			
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>A</b> Last <b>Gardiner</b>				4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1869</b>		9. AGE (In years lost birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Bowlen</b>				14. MOTHER'S MAIDEN NAME <b>Edmonia Candler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>7902 Kreeger Dr.</b> Address <b>Mrs. Buttell-daughter-Adelphi, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral thrombosis</b> DUE TO (c) <b>atherosclerosis sen'iled</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>1 month</b> <b>sev'l yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/16/61</b> , 19 <b>61</b> , to <b>11/14/61</b> , that I last saw the deceased alive on <b>11/11/61</b> , and that death occurred at <b>3 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald Nelson</b>				ADDRESS (Street, city or town, state) <b>10620 Georgia Ave, S.S., Md</b>		DATE SIGNED <b>11/14/61</b>	
PHYSICIAN'S NAME (Type) <b>10620 Doneld Nelson</b>				10620 Georgia Ave. Silver Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Barnesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 16 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1326

CERTIFICATE OF DEATH

12781

Longevity

Maryland

Montgomery

Ednor

Rockville

Belmont Nursing Home

None

Marie

Cardinal

November 14

Female White

Sept. 4, 1889

2

Housewife

Maryland

12A

George W. Bowler

Edmunds Chandler

7903 River Dr.

Mrs. Subell-Schubert-Alford, Md.

None

None

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

Item 23b, Film G299 11/8/61 iwr

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Falls Church</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1624 Hickory Hill Road</u> d. STREET ADDRESS <u>1624 Hickory Hill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Mae</u> Last <u>Getts</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>19 61</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 23, 1907</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marshall Ward</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Mercer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>HUSBAND: Robert H. Getts, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterus</u> DUE TO (b) <u>180X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>180X</u> DUE TO (c) <u>180X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>180X</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that <u>He</u> (this hospital) attended the deceased from <u>October 23, 1961</u> , to <u>November 1, 1961</u> , that <u>He</u> (we) last saw the deceased alive on <u>November 1, 1961</u> , and that death occurred at <u>11:55 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William P. Urshel</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>November 2, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM P. URSHEL LT MC USN</u>			
22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>11/6/1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>			
24. GENERAL DIRECTOR'S SIGNATURE <u>Mac S. Morris</u> ADDRESS <u>Va. 3901 N. Fairfax Dr., Arlington</u>			
25a. REC'D BY REGISTRAR <u>NOV 6 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1588

CERTIFICATE OF DEATH

1588

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1  
FOR STATE  
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div> 12806 </div> <div> <div> MONTGOMERY </div> <div> 12793 </div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park						c. LENGTH OF STAY IN 1b 2 1/2 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Louis WILLIAM LOUIS GIBSON						4. DATE OF DEATH Month 11/21/61 Day 19 Year 19					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/9/97		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Gibson						14. MOTHER'S MAIDEN NAME Eleanor Barrett					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579-03-1709		17. INFORMANT Hospital records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <div> <div> 332X </div> <div> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION, RT. OCCIPITAL  <div> DUE TO  <div> PULMONARY AND CEREBRAL EDEMA </div> </div> </div> </div>											

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12807

CERTIFICATE OF DEATH

Reg. Dist. No. 12794

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30 Silver Spring MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JENNIE GILBERT</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 27 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 20 - 1895</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9c. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	10c. BIRTHPLACE (State or foreign country) <u>POLAND</u>
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>KOPPEL DZIK</u>		14. MOTHER'S MAIDEN NAME <u>BELLA STAWICKY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>DANIEL GILBERT</u> Address <u>9501-DALLAS AVE, SS-MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial degeneration</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Thymus</u> (b) <u>—</u> (c) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 29</u> , 19 <u>61</u> , to <u>Nov 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov 26</u> , 19 <u>61</u> , and that death occurred at <u>3:10</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600-CARROLL AVE. TAK. PK. MD.</u> DATE SIGNED <u>Nov 27/61</u> ACTUAL SIGNATURE <u>Raymond O. West</u> M.D. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV-28-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CAPITAL HEB. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY &amp; SONS - 3501-14th St.</u> ADDRESS <u>N.W.</u>		24a. REC'D BY REGISTRAR <u>Nov 29 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
12808					12795									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY Montgomery MARYLAND					a. STATE Iowa									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Keokuk									
c. LENGTH OF STAY IN 1b 191 days					d. STREET ADDRESS 701 Franklin Street									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last Earl Eugene Gildersleeve					Month Day Year November 8 1961									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Male		Caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 19, 1897		64 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
Foreign Service Officer Diplomat						Iowa		USA						
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
William Homer Gildersleeve					Mary Anna State									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
Yes WW I					347 09 9496					WIFE: Ellia L. Gildersleeve, Same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma														
199X DUE TO														
Conditions, if any, which gave rise to immediate cause (b)														
(a), stating the underlying cause last. DUE TO														
(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (X) (this hospital) attended the deceased from May 2, 1961 to November 8, 1961, that (X) (we) last saw the deceased alive on November 8, 1961, and that death occurred at 1:20 PM from the causes and on the date stated above.														
22a. SIGNATURE Arthur S. Kettering M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED November 9, 1961						
22c. PHYSICIAN'S NAME (Type) U. S. Naval Hospital, Bethesda, Md.						22d. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11-14-61			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) Keokuk, Iowa					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey						ADDRESS Bethesda, Maryland			25a. REC'D BY REGISTRAR DATE NOV 15 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kettering			

12808

CENTRAL BANK OF AMERICA

12808

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Warrant for the arrest of

Warrant for the arrest of

12-11-1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12809

12796

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs, Md.</u> d. STREET ADDRESS <u>#6 Normandy Dr.</u>			
3. NAME OF DECEASED (Type or print) <u>Dora Belle Gorton</u>		4. DATE OF DEATH <u>11-1-1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-78</u>		9. AGE (In years last birthday) <u>83</u>		10. IF UNDER 1 YEAR <u>83</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. America</u>	
13. FATHER'S NAME <u>James F. Simmons</u>		14. MOTHER'S MAIDEN NAME <u>Martha Benton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Washington San &amp; Hosp. Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyphostatic Pneumonia</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease with heart failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours 7 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>61</u> , to <u>11/1</u> , 19 <u>61</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>11/1</u> , 19 <u>61</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11/1/61</u>		22c. PHYSICIAN'S NAME (Type) <u>HUGH W. IREY</u>		22d. ADDRESS <u>7105-Riggs Rd., Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-6-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Inc.</u>		24b. ADDRESS <u>Silver Spring, Md.</u>		25. REC'D BY REGISTRAR <u>NOV 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12810

12797

1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Simpsonville</i>	
c. LENGTH OF STAY IN 1b <i>3 days</i>		d. STREET ADDRESS <i>21 Donleigh Drive</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San. &amp; Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Anna Francis Goff</i>		4. DATE OF DEATH Month <i>11</i> Day <i>12</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-8-07</i>
9. AGE (In years last birthday) <i>54</i>		IF UNDER 1 YEAR Months <i>5</i> Days <i>1</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Conn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Hester</i>		14. MOTHER'S MAIDEN NAME <i>Mary Donovan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give number or date of service)	
17. INFORMANT <i>Wash. San. &amp; Hosp. Chart</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Auricular fibrillation</i> <i>500X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Congestive heart failure</i> (c) <i>Acute bronchitis + pneumonia viral</i> cause last, stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>3-4 days</i> <i>3-4 weeks</i> <i>3-4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Tuberculosis; left thoracoplasty 1940</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>008X</i>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11-6-</i> <i>1961</i> to <i>11-12-</i> <i>1961</i> , that (I) (we) last saw the deceased alive on <i>11-12-</i> <i>1961</i> , and that death occurred at <i>4 P.</i> M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles R. Shultz, MD</i> M.D.		22b. DATE SIGNED <i>11-12-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>CHARLES R. SHULTZ</i>		22d. ADDRESS <i>9 Sewey Drive Ellicott City, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-transit 11-13-61</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>Cunningham Mem. Park</i>		23d. LOCATION (City, town or county) (State) <i>St. Albans, West Va.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		25a. REC'D BY REGISTRAR <i>NOV 16 '61</i>	
ADDRESS <i>Bethesda, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Robert A. Lummery" and "Bethesda, Md." are faintly visible.]*

## CERTIFICATE OF DEATH

Reg. Dist. No. 12798

12811

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> 48	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4800 CHEVY CHASE DRIVE</b>		d. STREET ADDRESS <b>4800 CHEVY CHASE DRIVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>DR. MAURICE A. GOLDBERG</b>		4. DATE OF DEATH Month Day Year <b>Nov. 8, 1961</b> 19	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 29, 1904</b>
9. AGE (In years lost birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MINNESOTA</b>	
11. BIRTHPLACE (State or foreign country) <b>MINNESOTA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL GOLDBERG</b>		14. MOTHER'S MAIDEN NAME <b>ESTHER BELLE WILNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-44-1695</b>	
17. INFORMANT <b>MRS. RUTH M. GOLDBERG</b>		Address <b>4800 Chevy Chase Dr., Bethl., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Arterio sclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b> <b>Years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/6</b> to <b>11/8</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>11/6</b> , 19 <b>61</b> , and that death occurred at <b>5:10</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4709 Montgomery Lane, Beth., Md.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>Paul D. Cantor</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Paul D. Cantor</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Danzansky &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>NOV 13 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hance</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1281

CERTIFICATE OF DEATH

1281



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12812

CERTIFICATE OF DEATH

Reg. Dist. No. 12789

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>		c. LENGTH OF STAY IN 1b <u>4 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Del Pre Nursing Home</u>		d. STREET ADDRESS <u>12018 MILTON STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Henry</u> Last <u>Greatorex</u>		4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1892</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. GOVT.</u>	
11. BIRTHPLACE (State or foreign country) <u>Shelton, Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM GREATOREX</u>		14. MOTHER'S MAIDEN NAME <u>MARY ROBINSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>578-14-0765</u>	
17. INFORMANT <u>JEAN T. KISSINGER</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac vascular disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-29-61</u> , 19 <u>61</u> , to <u>Nov 24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>61</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3701 Leland ST</u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>J. R. Reedy</u>		M.D. <u>Chery Chase M.D.</u>	
PHYSICIAN'S NAME (Type) <u>J. R. Reedy</u>		M.D. <u>Chery Chase M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-28-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Collins</u>		24. REC'D BY REGISTRAR <u>Arthur S. Kiser</u>	
ADDRESS <u>3821-145th Ave, D.C.</u>		DATE <u>NOV 27 '61</u>	

MEDICAL CERTIFICATION

1891

STATE OF OHIO

1891

(M)

County of Hamilton, Ohio  
I, the undersigned, Clerk of the Court of Common Pleas for the County of Hamilton, Ohio, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the Court of Common Pleas for the County of Hamilton, Ohio.  
In testimony whereof, I have hereunto set my hand and the seal of the Court of Common Pleas for the County of Hamilton, Ohio, at Hamilton, Ohio, this 1st day of January, 1891.  
Clerk of the Court of Common Pleas for the County of Hamilton, Ohio.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12813

12800

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>33 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lanham</b> d. STREET ADDRESS <b>7706 Finns Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Michael Robert Griffin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 13, 1956</b>
9. AGE (In years last birthday) <b>5 yrs.</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b>	IF UNDER 24 HRS. Hours <b>5</b> Min. <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>District of Columbia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert A. Griffin</b>	
14. MOTHER'S MAIDEN NAME <b>Wilda Tusing</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMATION <b>The Medical Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suppurative pneumonia with multiple abscess formation</b> DUE TO (b) <b>Gastrointestinal hemorrhage</b> DUE TO (c) <b>Acute lymphocytic leukemia</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>204.2</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>9 days</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>October 18, 1961</b>		20g. (County) <b>Prince Georges</b>	
20h. (State) <b>Md.</b>		20i. (City or town) <b>1:45AM</b>	
21. I certify that (X) (this hospital) attended the deceased from <b>October 18, 1961</b> to <b>November 20, 1961</b> , that (X) (we) last saw the deceased alive on <b>November 20, 1961</b> , and that death occurred at <b>1:45AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. David Heywood</b> 22c. PHYSICIAN'S NAME (Type) <b>J. David Heywood, M.D.</b>		22b. DATE SIGNED <b>November 20-1961</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>		22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/22/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>		25. REC'D BY REGISTRAR <b>NOV 24 61</b>	
25a. ADDRESS <b>Hyattsville, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Smith</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12814

## CERTIFICATE OF DEATH

12801

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN lb <b>1 hour</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b> d. STREET ADDRESS <b>ROUTE 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>GREENBERRY GAITHER GRIFFITH</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>11 22 19 61</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>4/10/74</b>	<b>8. DATE OF BIRTH</b> <b>87</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farmer</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>CHARLES H. GRIFFITH</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>HESTER DORSEY</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>-</b>	
<b>17. INFORMANT</b> <b>HOSPITAL RECORDS</b>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY THROMBOSIS</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>ADENOCARCINOMA OF PROSTATE GLAND.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ADENOCARCINOMA OF PROSTATE GLAND.</b> INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL YRS.</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State) <b>MAY 11-22 1961</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>MAY 11-22 1961</b> <b>8:55A</b> <b>to</b> <b>11-22 1961</b> , that (I) (we) last saw the deceased alive on <b>11-22 1961</b> , and that death occurred at <b>11-22 1961</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Jack Schumacher</b> M.D.		<b>22b. DATE SIGNED</b> <b>11-22-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>JACK SCHUMACHER, M.D.</b>		<b>22d. ADDRESS</b> <b>GAITHERSBURG, MARYLAND</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11-25-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Goshen Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Goshen, Montgomery, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Francis X. Barber</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 29 '61</b>	
<b>ADDRESS</b> <b>Laytonsville, Md.</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>William L. Thomas</b>	

1938

CERTIFICATE OF DEATH

1938

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1

DECEASED

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF CEMETERY

NAME OF CLERGYMAN

DATE OF CREMATION

PLACE OF CREMATION

NAME OF CREMATOR

NAME OF CLERGYMAN

DATE OF REINTERMENT

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NAME OF FUNERAL HOME

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NAME OF MINISTER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12815

12802

Item 23b, Film G301-11/29/61 iwk  
Item 14-Film G302-11/29/61 iwk

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (Rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ESSEX (Rural- Baltimore)</b> 03x-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. NAVAL HOSPITAL</b>		d. STREET ADDRESS <b>1107 OLD EASTERN AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANKLIN</b> Middle <b>LEON</b> Last <b>GROUT, III</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 24, 1941</b> 20 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. NAVY</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. Months Days
13. FATHER'S NAME <b>FRANKLIN LEON GROUT, JR.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>LOCKPORT, NEW YORK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO. <b>066-32-6208</b>		14. MOTHER'S MAIDEN NAME <b>ALVAH ELIZABETH LOOMIS</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO (b) <b>Carcinoma Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>199X</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCT. 27, 1961</b> to <b>NOV. 23, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOV. 23, 1961</b> , and that death occurred at <b>4:55 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. F. Warrender</b> M.D.		22b. DATE SIGNED <b>Nov. 24, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. F. WARRENDER LT MC USN</b>		22d. ADDRESS <b>U. S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 25, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>White Chapel</b>	23d. LOCATION (City, town or county) (State) <b>Tonawanda, New York</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Funeral Home</b> W.W. Chambers Funeral Home, 1400 Chapin St. NW, WDC		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinner</b>			

14

MONTGOMERY

WASHINGTON (Army)

U. S. NAVAL HOSPITAL

FRANKLIN

LEON

GRANT, III

NOVEMBER 23

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MALE CAUC.

U. S. NAVY

LOCKPORT, NEW YORK

U.S.A.

FRANKLIN LEON GRANT, JR.

ELIZABETH LOOMIS

YES 066-32-8208 HOSPITAL RECORDS

4:55PM

OCT. 24

NOV. 23

61

U. S. NAVAL HOSPITAL, PETHESDA, MD.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12816

12803

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7216 Holly Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELIZABETH</b> First <b>HOWARD</b> Middle <b>GERRY</b> Last				4. DATE OF DEATH <b>Nov 25 1961</b> Month <b>Nov</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 OCT 1871</b>	
9. AGE (In years lost birthday) <b>90</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Louie M. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Franklin Catherine Beeler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Self (Pre-Arrangement)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1 Mar 1960</b> to <b>25 Nov 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>23 Nov 1961</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas P. Fogarty</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>25 Nov 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS P. FOGARTY</b>				22d. ADDRESS <b>1871 UNIV. BLVD EAST SILVER SPRING MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/28/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 28 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

12810

CERTIFICATE OF DEATH

12810



*[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Place of Death. The text is mirrored and difficult to read.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12815

12804

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN lb <u>66 days</u>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		d. STREET ADDRESS <u>1 Taney Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Greham Halpine</u>		4. DATE OF DEATH <u>November 3, 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>April 22, 1893</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Administration</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nicholas Halpine</u>		14. MOTHER'S MAIDEN NAME <u>Alice Macomb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>WIFE: Mrs. Helen B. Halpine, same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Pulmonary Emboli</u> DUE TO <u>Phlebitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Metastatic Carcinoma</u> DUE TO <u>Metastatic Carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>unknown</u> <u>3 months</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>August 30, 1961</u> , to <u>November 3, 1961</u> , that <u>11</u> (we) last saw the deceased alive on <u>November 3, 1961</u> , and that death occurred at <u>16:30 AM</u> from the causes and on the date stated above.			
22. SIGNATURE <u>William P. Baker</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>November 3, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM P. BAKER LT MC USN</u>			
22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>11-7-61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Annapolis, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>14711 Gloucester St., Annapolis</u> MD. 25a. REC'D BY REGISTRAR <u>NOV 6 1961</u> 25b. REGISTRAR'S SIGNATURE <u>John M. Taylor</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. 12805

12819

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>DC</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OLNEY</i>		c. LENGTH OF STAY IN 1b <i>3rd</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <i>5923 4th ST. N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>Katie</i> First <i>I. Hancock</i> Middle <i>I.</i> Last		4. DATE OF DEATH <i>Nov. 20</i> Month <i>Nov.</i> Day <i>20</i> Year <i>1961</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>conc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19 1883</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Wash DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Harry Hunnaker</i>		14. MOTHER'S MAIDEN NAME <i>Louise Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>3923 4th St N.W. DC</i>	
17. INFORMANT <i>Harry Hancock</i> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Colon (Sigmoid)</i> 153-8 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <i>11/16/61</i>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>9/14</i> , 19 <i>61</i> , to <i>11/20</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>11/16/61</i> , 19 <i>61</i> , and that death occurred at <i>6:15</i> A.M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>John P. Martin, MD</i>		ADDRESS (Street, city or town, state) <i>Sandy Spring, Md</i>	
PHYSICIAN'S NAME (Type) <i>John P. Martin, MD</i>		DATE SIGNED <i>11/20/61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-22-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rest Home</i>		ADDRESS <i>4812 G.A. Ave N.W.</i>	
24a. REC'D BY REGISTRAR <i>NOV 21 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Brook's Grove Foundation

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12820

## CERTIFICATE OF DEATH

Item 8 Film G302

12/13/61 iwk

12806

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>		c. LENGTH OF STAY in 1b <b>Other</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Germantown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>Rt. #1</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Robert Donald Harding</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>Nov. 29, 1961</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>Oct. 14, 1893</b>		<b>9. AGE (In years last birthday)</b> <b>68 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Atomic Energy Comm.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Government</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		<b>13. FATHER'S NAME</b> <b>Zacharias Harding</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Grace Hodgson</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Hospital Records</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>330X</b> <b>SUBARACHNOID HEMORRHAGE, EXTENSIVE.</b> DUE TO (b) <b>RUPTURED ANEURYSM CEREBRAL ARTERY.</b> DUE TO (c) <b>Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>-</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Nov. 27, 1961</b> <b>to</b> <b>Nov. 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 29, 1961</b> , and that death occurred at <b>10:29 P</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>Jack Schumacher</b>		<b>22b. DATE SIGNED</b> <b>11-30-61</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>JACK SCHUMACHER, M.D.</b>	
<b>22d. ADDRESS</b> <b>GAITHERSBURG, MARYLAND</b>		<b>22e. REC'D BY REGISTRAR</b> <b>DEC 5 '61</b>			
<b>22f. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hanna</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			
<b>23b. DATE THEREOF</b> <b>1-2-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Forest Oak</b>		<b>23d. LOCATION (City, town or county)</b> <b>Gaithersburg Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ernest C. Gartner. Gaithersburg. Md.</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Office of the

Director of the

Department of the Interior

Washington, D.C.

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

Field

12821

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12807

MEDICAL CERTIFICATION	1. PLACE OF DEATH e. COUNTY	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE	b. COUNTY					
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH	Month	Day	Year		
	5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	Months	Days	Hours	Min.
	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	INTERVAL BETWEEN ONSET AND DEATH	
	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.)	20c. TIME OF INJURY	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED			
	22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country)	(State)			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12822													
12808													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Belt Pre Nursing Home</u> c. LENGTH OF STAY IN 1b <u>56 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bel Pre Nursing Home 2601 Bel Pre Rd.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>South Arlington</u> d. STREET ADDRESS <u>1607 26th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Irene Rebecca</u>			4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1961</u>			5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>10/3/87</u>			9. AGE (In years last birthday) <u>74</u> yrs.			IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>3</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Derby, Conn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN T. MC CARTHY</u>						14. MOTHER'S MAIDEN NAME <u>MARY G. LEONARD</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>MRS FRANCES A. BRADLEY</u>						17. INFORMANT Address <u>1607-26th St. South ARLINGTON, VA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cowpox Sclerosis</u> (c) <u>Myocardial infarctions</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 Mo.</u> <u>10 years</u> <u>3 years</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 14</u> , 19 <u>61</u> , to <u>Nov 28</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Nov 26</u> , 19 <u>61</u> , and that death occurred at <u>1:30 P</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Max G. Sherer MD</u>						22b. DATE SIGNED <u>11/28/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER MD</u>						22d. ADDRESS <u>2025 EAST West H'way S.W. Sp. Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>11/30/61</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Max G. Sherer</u>						25a. REC'D BY REGISTRAR <u>Dr. Arthur S. Fries</u>							
25b. REGISTRAR'S SIGNATURE						25c. DATE <u>NOV 30 '61</u>							

(M)

(I)

No

None

A.B.U.

Depy. Comm.

U.S. DEPT. OF JUSTICE  
DIVISION OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12823  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12809  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>18 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>California</b> b. COUNTY <b>San Gabriel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>410 East Sunset Avenue</b> d. STREET ADDRESS <b>43 X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Arthur (None) Hernandez</b>			4. DATE OF DEATH Month Day Year <b>November 2 19 61</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Spanish</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>December 4, 1934</b>		9. AGE (In years last birthday) <b>26</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>26</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>California</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Ralph Hernandez</b>			14. MOTHER'S MAIDEN NAME <b>Louise Vasquez</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Unascertainable</b>		
17. INFORMANT <b>The Medical Record</b>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Heart Disease - Tricuspid atresia</b> 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-operative hemorrhage following superior vena cava to right pulmonary artery anastomosis</b>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>26 years</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>October 15, 1961, November 2, 1961</b>		20g. (County) <b>4:50PM</b>		20h. (State) <b>that (u) (we) last saw the deceased alive on November 2, 1961, and that death occurred at 4:50PM from the causes and on the date stated above.</b>	
21. I certify that (this hospital) attended the deceased from <b>October 15, 1961, November 2, 1961</b> that (u) (we) last saw the deceased alive on <b>November 2, 1961</b> and that death occurred at <b>4:50PM</b> from the causes and on the date stated above.			22a. SIGNATURE <b>Richard P. Anderson</b> M.D. 22b. DATE SIGNED <b>11/4/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Richard P. Anderson, M.D.</b>			22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/8/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Alhambra, Calif.</b>	
23d. LOCATION (City, town or county) <b>Alhambra, Calif.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>		ADDRESS <b>Washington D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>					

(M)

Montgomery

California

Bedford

18 days

San Gabriel

The Clinical Center, Bethesda 11, Md.

110 East Sunset Avenue

Andover (Mass)

November

November

x

Spokane

Walla

December 1, 1934

Spokane

None

California

U.S.A.

Ralph Henderson

Los Angeles

The Medical Record

Unaccountable The Clinical Center, Bethesda 11, Maryland

No

Completed in re disease - Triphasic attack

lost-operate hemorrhage following superior vena cava resection

x

November

61

October 15, 1934

November 2

x

The Clinical Center, National Institutes of Health, Bethesda 11, Md.

Richard L. Anderson, M.D.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12824

12810

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in b. <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>2806-Hardy Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Neal M. Herndon</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>12</u> Year <u>1961</u>							
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/11/189</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>government</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Alabama</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>George Herndon</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Addie Linton</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT</b> (Name and address) <u>George L. Herndon, 2801-Wadsworth, Bethesda, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 200.1 DUE TO <u>Circulatory failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lymphosarcoma</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 Hrs</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1946</u> <b>to</b> <u>11/12, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>11/12, 1961</u> , <b>and that death occurred at</b> <u>4:30 PM</u> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>John W. Latimer, Jr.</u> M.D.						<b>22b. DATE SIGNED</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>John W. Latimer, Jr.</u>						<b>22d. ADDRESS</b> <u>1728 Mass Ave N.W. Wash. D.C.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>  </u>			<b>23b. DATE THEREOF</b> <u>11/15/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>November 15, 1961</u>				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. S. H. Nine Co.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>Wash. D.C.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2018-01-01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12825

## CERTIFICATE OF DEATH

12811

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>13 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 29</u> d. STREET ADDRESS <u>428 Pershing Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rosa Frances Hettinger</u>		4. DATE OF DEATH <u>November 5 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Treasury Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>William Lowe</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive failure of heart</u> DUE TO (b) <u>Myocardial infarction</u> (a), stating the underlying cause last. (c) <u>Coronary artery thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerotic cardiovascular disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 5, 1959</u> to <u>Nov 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 5, 1961</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest E. Farmer</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED	
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/8/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Prince George's County, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>434 Georgia Avenue Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 7 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 4, MARYLAND

## CERTIFICATE OF DEATH

12826

12812

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>7009 Clarendon Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>NATHAN K. HILL</b>		<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>10,</b> Year <b>1961</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 20, 1888</b>		<b>9. AGE</b> (In years last birthday) <b>73</b> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																		
Months	Days																		
Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Greens Cutter-Country Club-Retired</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Maryland</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U. S.</b>											
<b>13. FATHER'S NAME</b> <b>Levi Hill</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Julia Marsden</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>											
<b>16. SOCIAL SECURITY NO.</b> <b>219-01-3890</b>				<b>17. INFORMANT</b> <b>Wife</b> <b>Freida Hill</b>				Address <b>Same as Item.#2.</b>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Cerebro Vascular Accidents</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Hypertensive Heart Disease</b> (c) <b>DIABETES Mellitus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>10 YRS</b> <b>10 YRS</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Jan 1937</b> <b>to</b> <b>Nov 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 10 1961</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <b>Leo I. Donovan</b>				<b>22b. DATE SIGNED</b> <b>11-10-61</b>				<b>22c. PHYSICIAN'S NAME</b> (Type) <b>LEO I. DONOVAN</b>											
<b>22d. ADDRESS</b> <b>8218 Wisconsin Ave., Bethesda, Md.</b>				<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>															
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>11-13-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parklawn Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Rockville, Maryland</b>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. PUMPHREY</b>						ADDRESS <b>Bethesda, Md.</b>													
<b>25a. REC'D BY REGISTRAR</b> DATE <b>NOV 14 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1942

1942  
CERTIFICATE OF DEATH

Montgomery

Harvilland

Montgomery

Bedstead

Bedstead

7009 Clarendon Rd.

Suburban Hospital

Nov. 10, 41

HILL

NATHAN

Oct. 20, 1898

Male

U. S.

Harvilland

Greene Center-Country Club-retired

Julia Harvilland

Levi Hill

Name as listed

91-01-3890 Levi Hill

No

(1)

11-10-41  
8218 Whelan Rd., Bethesda, Md.

11-10-41

Kochville, Maryland

11-13-41

Partial

ROBERT A. KIMBLEY, Bethesda, Md.

1 **FOR STATE HEALTH DEPT.**

Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO DISTRICT MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
5M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**12827 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12813**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(rural)</u>	
c. LENGTH OF STAY in 1b <u>DOA</u>		d. STREET ADDRESS <u>1 R 7 J # 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Md R-107</u>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Kenneth Hood</u>		4. DATE OF DEATH <u>Nov 26 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-08</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George C. Hood</u>		14. MOTHER'S MAIDEN NAME <u>Florence Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Item # 2</u>	
17. INFORMANT <u>Mrs Evelyn Herbert</u>		Address <u>Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO (b) <u>Transsection of Aorta</u> (c) <u>Crushed Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>825X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver fear involved in accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:45 p.m. 11-26 1961</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Md R-107</u>	20f. (City or town) (County) (State) <u>Rockville Montg MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEIT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/30/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery.,</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Snowden</u>	

18851

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 9/59

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12828  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12814

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> 58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4601 Cooper Lane</b>		d. STREET ADDRESS <b>4601 Cooper Lane</b> 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>F</b> Last <b>Horne</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/22/1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>25</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>South Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert L. Horne</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth McFadden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Spanish American</b>		16. SOCIAL SECURITY NO. <b>577-03-1346</b>	
17. INFORMANT <b>Josephine M Horne, Wife-same above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute heart failure</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 21, 1961</b> to <b>Nov. 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 14, 1961</b> , and that death occurred <b>2:55 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C. P. Ryland</b>		22b. DATE SIGNED <b>11-17-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. P. RYLAND</b>		22d. ADDRESS <b>4400 - 49 ST NW Washington DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/20/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Geo. Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12829						12815					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Montgomery</b>						e. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colesville Md.</b>						b. COUNTY <b>Montgomery</b>					
c. LENGTH OF STAY IN 1b <b>36</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Marilea Nursing Home</b>						d. STREET ADDRESS <b>11,605 Gail Street</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>CARRIE GERTRUDE HURLEY</b>						4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>5</b> Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 1, 1892</b>		9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Calvert County, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Emory E. Berry</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Johnson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs. Harvey L. Glasscock</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Cardio-vascular arterio-sclerosis</b> (c) <b>Generalized arterio-sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 weeks</b> <b>4 yrs</b> <b>4 yrs</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Amputation of the left leg just above the knee.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>191 61</b>				20g. (County) <b>11/5/61</b>				20h. (State) <b>19</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>11/4/61</b> to <b>11/5/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/4/61</b> , 19 <b>61</b> , and that death occurred at <b>7 a.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Walter K. Angevine</b>						22b. DATE SIGNED <b>11/5/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Walter K. Angevine</b>						22d. ADDRESS <b>6300 13th St. N.W. Wash. DC</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/8/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>			
23d. LOCATION (City, town or county) <b>Washington D.C.</b>				23e. (State) <b>D.C.</b>				23f. (Country) <b>U.S.A.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond H. Ziska</b>				24a. ADDRESS <b>8434 Georgia Avenue</b>				24b. CITY OR TOWN <b>Silver Spring, Maryland</b>			
24c. NAME OF FUNERAL HOME <b>Warner E. Humphrey Inc.</b>				24d. ADDRESS <b>8434 Georgia Avenue</b>				24e. CITY OR TOWN <b>Silver Spring, Maryland</b>			
24f. PHONE NO. <b>444-1111</b>				24g. (State) <b>MD</b>				24h. (Country) <b>U.S.A.</b>			
25a. REC'D BY REGISTRAR <b>Nov 7 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>				25c. (State) <b>MD</b>			
25d. (Country) <b>U.S.A.</b>				25e. (City or town) <b>Silver Spring</b>				25f. (County) <b>Montgomery</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12830

## CERTIFICATE OF DEATH

12816

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>2 1/2 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
e. STREET ADDRESS <b>8516 Beach Tree Road.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Clara G. Hurley</b>				<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>21</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/7/06</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Alfred B. Gawler</b>				14. MOTHER'S MAIDEN NAME <b>Sally Hager</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-----</b>				16. SOCIAL SECURITY NO. <b>-----</b>			
17. INFORMANT <b>Glenn S. Hurley, husband</b>				Address <b>same as above</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Thrombosis</b> (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6-8 days</b> <b>6-8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 25, 1954</b> to <b>NOV. 21, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 21, 1961</b> , and that death occurred <b>11:10 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert G. Angle</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 21, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT G. ANGLE</b>				22d. ADDRESS <b>5009 DEL RAY AVENUE, BETHESDA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/24/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gaudens Sons</b>				ADDRESS <b>1736 Penna Ave.</b>		25a. REC'D BY REGISTRAR <b>NOV 24 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>							

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U.S.A.

Washington, D.C.

Housewife

Franklin D. Roosevelt

John F. Kennedy

Office of the President, White House

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1/1/06

2000 DEL RAY AVENUE, BETHESDA, MD.

WASHINGTON, D.C.

CAN HILL DELIVERY

1/1/06

BUFILE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12831												12817											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>												c. LENGTH OF STAY IN 1b <u>5 days</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval hospital</u>												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MCS Quantico</u>											
d. STREET ADDRESS <u>Qtrs. 2304B Chamberlain Village</u>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Arthur Lloyd Jackson</u>												4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1961</u>											
5. SEX <u>Male</u>												6. COLOR OR RACE <u>Negroid</u>											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH <u>Feb. 22, 1935</u>											
9. AGE (In years last birthday) <u>26</u> yrs.												10. IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min. <u>26</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Serviceman</u>												10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>											
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>												12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>Brandon Jackson</u>												14. MOTHER'S MAIDEN NAME <u>Unknown</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u>												16. SOCIAL SECURITY NO. <u>161-26-4789</u>											
17. INFORMANT <u>Hospital Records</u>												Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Stem Hemorrhage</u> DUE TO <u>basilar skull fracture</u> DUE TO <u>automobile accident</u>												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>												20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that <u>✓</u> (this hospital) attended the deceased from <u>Nov. 18, 1961</u> to <u>Nov. 22, 1961</u> that <u>✓</u> (we) last saw the deceased alive on <u>Nov. 22, 1961</u> , and that death occurred at <u>8:17 AM</u> from the causes and on the date stated above.												22a. SIGNATURE <u>G. A. Macid</u> M.D.											
22b. DATE <u>November 22, 1961</u>												22c. PHYSICIAN'S NAME (Type) <u>G. A. MACID LT MC USNR</u>											
22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>												22e. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>												23b. DATE THEREOF <u>11-27-61</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>												23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. T. Taylor Inc., 909 6th St NW, Washington, D.C.</u>												25. REC'D BY REGISTRAR <u>NOV 27 '61</u>											
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>																							

12837

CERTIFICATE OF DEATH

12837

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born 17th November  
1914 at [illegible]  
[illegible]

*[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12832				Item 23b, Film 3300 11/13/61 iwk				12818			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>Dallas</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>152 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dallas</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>						d. STREET ADDRESS <u>4211 Munger Ave</u>					
3. NAME OF DECEASED (Type or print) First <u>Opal</u> Middle <u>Vera</u> Last <u>Jackson</u>						4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>61</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 4, 1916</u>		9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mississippi</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jake Goodnight</u>						14. MOTHER'S MAIDEN NAME <u>Dora Rayborn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>- - - - -</u>					
17. INFORMANT <u>HUS: Deloyd Jackson, Same as #2</u>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GANGRENE OF LOWER EXTREMITIES</u> <u>450</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>PROGRESSIVE ARTERIAL OCCLUSION</u> (a), stating the underlying cause last. DUE TO (c) <u>ARTERIOSCLEROSIS</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>- - - - -</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 20, 1961</u> to <u>November 5, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 5, 1961</u> , and that death occurred at <u>5:40 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Benjamin J. Gilson</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>6 November 1961</u>					
22c. PHYSICIAN'S NAME (Type) <u>BENJAMIN J. GILSON LT MC USN</u>						22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> <u>TYSON WHEELER FUNERAL HOME,</u>						25a. REC'D BY REGISTRAR <u>1331</u> <u>Rockville, Md.</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>						DATE <u>NOV 8 '61</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12833

## CERTIFICATE OF DEATH

12819

Item 9 Film 9302 12/13/61 iwk

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>	
c. LENGTH OF STAY IN 1b <u>24 days</u>		d. STREET ADDRESS <u>Raymond St. 3704</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>RAY FISHER JACKSON</u>		<b>4. DATE OF DEATH</b> <u>Nov. 30 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>4/18/87</u>	9. AGE (In years last birthday) <u>74 7/8</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>EASH. D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CHARLES FISHER</u>		14. MOTHER'S MAIDEN NAME <u>ELLA DORAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-46-6407B</u>	
17. INFORMANT <u>HUSBAND FRANK JACKSON (SAME AS ABOVE)</u>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause prevailing for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left hemiplegia, severe</u> <u>334X</u> DUE TO <u>Right hemiplegia, severe, with aphasia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral arteriosclerosis, severe</u> causing the underlying cause listed. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u> <u>5 yrs x</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>APR 1947</u> to <u>Nov 30, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 30, 1961</u> , and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp M.D.</u>		22b. DATE SIGNED <u>12-1-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		22d. ADDRESS <u>4740 Chevy Chase Dr Chevy Chase Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>12/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City, town or county) <u>Suitland, Maryland</u> (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



12853

12853

(M)

(1)

Cerebral arterio-venous anastomosis, secretory type

Essential Hyperfunction

Stewart Clapp

Raymond Clapp

Robert A. Thompson, Bethesda, Maryland  
Creston 12451  
Gordon Hill Crematory, Southern, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12834				Item 6 Balm G301 11/29/61 iwk				12820			
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Richard W. Johnston				4. DATE OF DEATH November 17 1961							
5. SEX M				6. COLOR OR RACE W				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH May 29, 1917			
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. AGE (In years last birthday) 44 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Electronics				11. BIRTHPLACE (County & State, or foreign country) Boston - Mass			
12. CITIZEN OF WHAT COUNTRY? U.S. A.				13. MOTHER'S MAIDEN NAME Annie F. Perkins							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Brother John C. Johnston Jr			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 585X DUE TO Sepsicemia, type(?) Gangrene, gall bladder				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Cholecystectomy (11/15/1961)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 19				20g. (County) 19				20h. (State) 19			
21. I certify that (I) (this hospital) attended the deceased from 11-15-61, 19 to 11-17-61, 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE John O. Robben				22b. DATE SIGNED 11-18-61							
22c. PHYSICIAN'S NAME (Type) John O. Robben				22d. ADDRESS 10511 Summit Ave., Kensington, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/22/ 61				23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery			
23d. LOCATION (City, town or county) Arlington, Virginia				23e. REC'D BY REGISTRAR DATE NOV 22 '61				23f. REGISTRAR'S SIGNATURE Christy S. Kins			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland											

VR A15 (4)  
15M 9/60

12151

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Electronic

Business

Yes

Experiments (1958)  
Gangster, Philadelphia

Championship (1958)

John O. Robben  
1011 Summit Ave., Washington, D.C.

John O. Robben

Robert A. Ranshrey, Bethesda, Maryland  
11/22/51 Arlington Cemetery, Arlington, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12835

12821

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY in lb <b>11 3/4 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>302 Mansfield Road</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Nora Cecilia Kelley</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>15</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 23, 1871</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>	
<b>13. FATHER'S NAME</b> <b>Patrick Brodrick</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Lenard</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> 450.0 DUE TO (b) <b>Terminal Bronchopneumonia and</b> DUE TO (c) <b>Congestive Failure</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>May 8</b> , 19 <b>61</b> <b>to</b> <b>May 15</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11-15</b> , 19 <b>61</b> , and that death occurred at <b>5:45A</b> , from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <b>Dr. Kenneth F. Laughlin</b> M.D.	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. Kenneth F. Laughlin</b>		<b>22b. DATE SIGNED</b> <b>11-15-61</b>	
<b>23a. (BURIAL, CREMATION, REMOVAL) (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>11/18/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. John's Catholic Cemetery Forest Glen, Montgomery Md.</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Silver Spring, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Raymond A. Ziska</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 17 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>William S. Thoms</b>		<b>25c. REGISTRAR'S NAME</b> <b>William S. Thoms</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12836 CERTIFICATE OF DEATH 12832											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in 1b <b>1/2 hour</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution, Resided before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5411 Lincoln Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Thomas Edward Kennedy</b>						4. DATE OF DEATH <b>Nov. 12 1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1899</b>		9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hub Company</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Hampshire</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Thomas Kennedy</b>						14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>World War I</b>						16. SOCIAL SECURITY NO. <b>322-12-7078</b>		17. INFORMANT <b>Mrs. Sophia D. Kennedy</b> Address <b>5411 Lincoln Street, Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cardiac Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Myocardial Infarction</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>1 hr.</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1961</b> to <b>Nov. 1961</b> , that (I) (we) last saw the deceased alive on <b>November 12 1961</b> , and that death occurred at <b>8:54 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Ralph F. Patten</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>RALPH F. PATTEN M.D.</b>						22d. ADDRESS <b>8641 Colsonville Road Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Virginia</b>		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond W. Rishay</b> ADDRESS <b>8434 Georgia Avenue</b>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		
Warner E. Pumphrey, Inc. Silver Spring, Maryland						DATE <b>NOV 14 '61</b>					

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 1301 PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12823

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>26 days</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Mont. Co.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 X-3 Kensington Washington, D.C.</b>		d. STREET ADDRESS <b>1424 Somerset Place N. Kensington Gardens Nursing Home</b>		e. IS RESIDENCE A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) <b>Ina B. Kepner</b>		First		Middle		Last		4. DATE OF DEATH <b>Nov. 12, 1961</b>		Month		Day		Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/17/72</b>		9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>A. Peter</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Black</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Elizabeth C. George Silver Spg. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>332 X</b> IMMEDIATE CAUSE (a) <b>Cerebral infarction</b> DUE TO (b) <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of left femur</b> 5 weeks		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <b>Fell from chair in her room at nursing home - fracture of hip</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>4:30 p.m. 10-16 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nursing home</b>		20f. (City or town) <b>Kensington Mont. Md.</b>		20g. (County) <b>Montgomery</b>		20h. (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11-13-61</b>									
ACTUAL SIGNATURE <b>Frank J. Broschant</b>		EXAMINER'S NAME (Type) <b>FRANK J. Broschant</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation 11/15/61</b>		22b. DATE THEREOF <b>11/15/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory Prince Georges Co. Md.</b>		22d. LOCATION (City, town, or country) <b>Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>NOV 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

FOR SALE  
BY THE BUREAU



12001

Belmont  
20 days

Shuman

1000

1000

Ohio

Hanswiler

1000

none

no

Mississippi

Mrs. Elizabeth C. George Silver

The S. H. Hines Co. 2901 12th St. N.W.  
Washington, D.C.  
12001

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12838

12824

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>9715 Culver St</u>			
3. NAME OF DECEASED (Type or print) <u>Albert Francis Klatt</u>				4. DATE OF DEATH <u>November 1, 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 16, 1875</u>	
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired- Printer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore-Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Norman Klatt</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease (major)</u> DUE TO (c) <u>(major)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>10-5-</u>				20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-5-</u> 19 <u>61</u> , to <u>11-1-</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> 19 <u>61</u> and that death occurred at <u>2:10</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>J. P. Martin, M.D.</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>J. P. Martin</u>				22d. ADDRESS <u>Sandy Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15451

CERTIFICATE OF DEATH

15451

M

1

James W. Koff  
Age 18-19  
Born 1872  
Died 1892  
Cause of Death  
Hospital Report

James W. Koff  
Age 18-19  
Born 1872  
Died 1892  
Cause of Death  
Hospital Report

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12839

## CERTIFICATE OF DEATH

12825

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN TB <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>99 ELM AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JOSEPHINE</u> Middle <u>ACHILLES</u> Last <u>KLING</u>		<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>11</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-5-80</u>
<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>United States</u>		<b>13. FATHER'S NAME</b> <u>Melvin LeGrand</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Augusta Wilmanns</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes give year or dates of service)	
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Hospital Records</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Cardio-Vascular-Renal Syndrome</u> DUE TO (c) <u>Cerebro-vascular accident</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Right hemiplegia</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 10, 1961</u> <b>to</b> <u>Nov. 11, 1961</u> <b>that (I) last saw the deceased alive on</b> <u>Nov. 10, 1961</u> <b>and that death occurred at</b> <u>1:38 A.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Lyndon R. Heiges</u>		<b>22b. DATE SIGNED</b> <u>Nov. 11, 1961</u>	<b>22c. PHYSICIAN'S NAME (Type)</b> <u>LYNWOOD HEIGES, MD, FACA</u>
<b>22d. ADDRESS</b> <u>6940 Piney Branch Road, N. W., Washington 12, D. C.</u>		<b>22e. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>11/15/61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ALLEGHENY CO. MEM. PARK</u>	<b>23d. LOCATION (City, town or county)</b> (State) <u>PITTSBURGH, PA.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Real Funeral Home</u>		<b>24b. ADDRESS</b> <u>4812 GAVE NW</u>	<b>24c. DATE</b> <u>NOV 16 '61</u>
<b>24d. REC'D BY REGISTRAR</b>		<b>24e. REGISTRAR'S SIGNATURE</b> <u>Charles S. Harris</u>	

15230

15230

(M)

(1)

*Carroll's letter  
to the President  
of the American  
Society of  
Physicians*

*1877-78*

*1877-78*

LYNWOOD HIGGS, MD. FACS  
2240 Piney Branch Road, N. W.  
Washington, D. C.

*1877-78*



1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>md</i> b. COUNTY <i>mmty</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>50 Bethesda</i>	
c. LENGTH OF STAY in 1b <i>life</i>		d. STREET ADDRESS <i>4307 Rosedale Ave</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4307 Rosedale Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Patricia Ann Kober</i>		4. DATE OF DEATH <i>Nov 29 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-24-57</i>
9. AGE (In years last birthday) <i>3</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>DE.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U-S A</i>	
13. FATHER'S NAME <i>Eduard B. Kober</i>		14. MOTHER'S MAIDEN NAME <i>Helen Day</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Np</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Eduard B. Kober (father)</i>		Address <i>Stm 2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> <i>587.3</i> DUE TO (b) <i>Mucopurulent distention of bronchi</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Emphysema</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i> <i>3 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <i>11-30-61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/2/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>	22d. LOCATION (City, town, or country) (State) <i>Silver Spring, Maryland</i>
23. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		24a. REC'D BY REGISTRAR <i>DEC 1 '61</i>	
ADDRESS <i>Bethesda, Maryland</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanes</i>	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

15308

MEDICAL EXAMINATION REPORT

15308



Robert A. [illegible]

State of Maryland, [illegible]

1 ~~2~~  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div> </div> <div> <div>5</div> <div>6</div> </div>									
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12842

12828

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Derwood</u> d. STREET ADDRESS <u>Route #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DORA</u> First Middle Last 5. SEX <u>fe</u> 6. COLOR OR RACE <u>wh</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>11 21 1961</u> Month Day Year 8. DATE OF BIRTH <u>8-1-'79</u> 9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Mrs. Nancy Lea Smith - AS</u> Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Primary carcinoma of Liver (type ?)</u> 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1/1961</u> to <u>11/21/1961</u> , that (I) (we) last saw the deceased alive on <u>11/21/1961</u> , and that death occurred <u>11/21/1961</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen R. Jones</u> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <u>11/21/61</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11/22/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Chattanooga, Tenn</u> 23d. LOCATION (City, town or county) (State) <u>Chattanooga Tenn</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u> ADDRESS <u>4812 Ga. Ave N.W.</u> 25a. REC'D BY REGISTRAR <u>NOV 29 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Jones</u>	

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(M)

(A)

*[Faint, mostly illegible handwritten text, possibly a letter or report. Some words like "Dear" and "to" are visible.]*

*[Faint, mostly illegible handwritten text, continuing from the previous section. Some words like "Very truly yours" and "Sincerely" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
12843		12829	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY <u>Montgomery</u>		a. STATE <u>Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY IN 1b <u>6 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium + Hospital</u>		d. STREET ADDRESS <u>6424 - 5th Ave</u>	
3. NAME OF DECEASED (Type or print)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First <u>Robert</u>		Last <u>Brooke</u>	
Middle <u>Leizear</u>		4. DATE OF DEATH Month <u>11</u>	
5. SEX <u>Male</u>		Day <u>18</u>	
6. COLOR OR RACE <u>White</u>		Year <u>19 61</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-12-80</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seminary Caretaker</u>		IF UNDER 24 HRS. Days <u>18</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Rock Creek Cemetery</u>		Hours <u>6</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Leizear</u>		14. MOTHER'S MAIDEN NAME <u>Rachael unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>377-01-0897</u>	
17. INFORMANT <u>Mildred E. Byron</u>		Address <u>Same as #2 (daughter)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive heart failure</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u>			
(c) <u>Arteriosclerosis generalized</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pyelonephritis, chronic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>May 11-18-61</u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>May</u>		20f. (City or town) <u>1961</u>	
20g. (County) <u>Nov.</u>		20h. (State) <u>1961</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>May 11-18-61</u> to <u>Nov. 18-61</u> , that (I) (we) last saw the deceased alive on <u>11-18-61</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Aldo Vacca</u>	
22b. DATE SIGNED <u>11-18-61</u>		22c. PHYSICIAN'S NAME (Type) <u>ALDO VACCA</u>	
22d. ADDRESS <u>1427 University Blvd, W. Silver Spring, Md.</u>		22e. REC'D BY REGISTRAR <u>NOV 21 '61</u>	
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>11/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	
23d. LOCATION (City, town or county) <u>Washington D. C.</u>		23e. REC'D BY REGISTRAR <u>NOV 21 '61</u>	
23f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>	
24a. ADDRESS <u>Hyattsville, Md.</u>		24b. DATE <u>NOV 21 '61</u>	

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CERTIFICATE OF BIRTH

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Alabama Park

Alabama Park

West, Montgomery & Hospital at 24 - 25 Ave

Robert Brooks

Male White 7-12-30 21

County Clerk - Montgomery

Robert

Montgomery, Alabama

Montgomery, Alabama

Montgomery, Alabama

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Washington, D.C.

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Pataville, Ind.

Franklin's Book

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Nheaton Md.</u> c. LENGTH OF STAY IN 1b <u>83 days.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BEL PEE NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> g. STREET ADDRESS <u>2230-29TH PL., N.W.</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SARAH C LEVENSON</u>		4. DATE OF DEATH <u>11 25 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 18 92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE - HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS Sheldon Wilkes</u>		Address <u>2500 Ross Rd. S.S.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <u>260X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>5 years</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Parkinson's Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/2</u> 19 <u>61</u> to <u>11/26</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/25</u> 19 <u>61</u> , and that death occurred at <u>4:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Max G. Sherer</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MAX SHERER, M.D.</u>		22d. ADDRESS <u>2025 EAST WEST Hwy Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>NOV. 27, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>HYATTSVILLE MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danyachuk</u>		25a. REC'D BY REGISTRAR <u>3501-14 ST. 2nd</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		DATE <u>NOV 28 '61</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12845 CERTIFICATE OF DEATH 12831

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>2 wks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Saniterium + Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>222 Farragut St. N.W.</b> 49x3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Stella Ruth Lewis</b>		4. DATE OF DEATH <b>November 26 1961</b>		9. AGE (In years last birthday) <b>78</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dept. of Commerce</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>			
13. FATHER'S NAME <b>John Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Veazie</b>		17. INFORMANT <b>Hosp. records</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>		17. ADDRESS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis left internal carotid artery</b> DUE TO (b) <b>Cerebral arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>25 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/12</b> 19 <b>61</b> to <b>11/26</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/26</b> 19 <b>61</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Samuel M. Bageant</b>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Samuel M. Bageant</b>			
22d. ADDRESS <b>5600 N.H. Ave Wash., D.C.</b>		22e. REC'D BY REGISTRAR <b>NOV 28 '61</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>11/29/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			
23d. LOCATION (City, town or county) <b>Prince Georges County, Md.</b>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b> 2901 14th St/ N. Washington, D.C.							

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Montgomery

Town Park

Stella

Female White

Tellin Harris

District of Columbia

Starks Washington

Washington Sanitarium, in the city of Washington, D.C.

North

2-23-23

Mississippi

Charlotte Harbor

Harbor

Shirley's of London, England

London, England

Upper course of the river

11/12/23

11/23/23

2200 N. H. Ave. Wash. D.C.

THE S. E. LINES CO. LTD. LONDON, ENGLAND



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FOR STATE  
HEALTH DEPT.

(M)

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MEDICAL CERTIFICATION

2

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12832											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. LENGTH OF STAY in 1b <b>20 mins.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>59 BETHESDA</b>				d. STREET ADDRESS <b>7009 AMY LANE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>PHILIP</b> Last <b>LITCKE</b>						4. DATE OF DEATH Month <b>NOV.</b> Day <b>23</b> Year <b>19 61</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 31, 1927</b>		9. AGE (in years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>C.I.A.</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Oregon</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.C.</b>	
13. FATHER'S NAME <b>Philip Littke</b>						14. MOTHER'S M maiden NAME <b>Lena Stillman</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>WW 2</b>				16. SOCIAL SECURITY NO. <b>544-24-4224</b>		17. INFORMANT <b>Police Record</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage + laceration</b> <b>976 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>gun shot wound</b> (c), stating the underlying cause last. <b>Head practically decapitated</b>										<b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
<b>Was a mental pt on leave from St Eliz Hosp</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self-inflicted gun shot wound</b>							
20c. TIME OF INJURY Month, Day, Year Hour <b>12:45</b> <b>p.m.</b> <b>11-23 1961</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Bethesda</b>		(County) <b>Montg</b> (State) <b>md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Frank J. Brochart</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county)						<b>11-23-61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/27/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Maryland</b>						24a. REC'D BY REGISTRAR <b>NOV 30 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

1948

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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12833										
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>montg</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sandy Spring</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>13 Sandy Spring</i>					
c. LENGTH OF STAY IN 1b <i>3 yrs</i>					d. STREET ADDRESS <i>1 Brook Road</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Brook Road</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Nellie</i> Middle <i>Lynn</i> Last <i>Lyne</i>					4. DATE OF DEATH Month <i>nov</i> Day <i>17</i> Year <i>1961</i>					
5. SEX <i>fe</i>		6. COLOR OR RACE <i>col</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (in years last birthday) <i>57</i> yrs.		9. IF UNDER 1 YEAR Months <i>57</i> Days <i>04</i> Hours <i>00</i> Min. <i>00</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic</i>					10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <i>md</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Joe. Lyne</i>					14. MOTHER'S MAIDEN NAME <i>Mary Carter</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>					16. SOCIAL SECURITY NO. <i>1-27-04</i>					
17. INFORMANT <i>Rosie Afford</i>					Address <i>Itum 2</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Found dead in bed</i> DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>19</i> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
ACTUAL SIGNATURE <i>Frank J. Brosehart</i> M.D.					DATE SIGNED <i>11-17-61</i>					
EXAMINER'S NAME (Type) <i>Frank J. Brosehart</i>					Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			22b. DATE THEREOF <i>11/20/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ash Memorial.</i>		22d. LOCATION (City, town, or country) (State) <i>Sandy Spring, Md.</i>			
23. FUNERAL DIRECTOR <i>Robert L. Suorden</i>					ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 24 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12834

Item 6 Film G302 12/18/61 iwk

<b>1. PLACE OF DEATH</b> a. COUNTY <p style="text-align: center;">Montgomery</p> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <p style="text-align: center;">Bethesda</p> c. LENGTH OF STAY IN 1b <p style="text-align: center;">90 days</p> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <p style="text-align: center;">The Clinical Center, Bethesda 14, Md.</p>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <p style="text-align: center;">New Jersey</p> b. COUNTY <p style="text-align: center;">Bellmawr</p> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <p style="text-align: center;">19 Apple Avenue</p> d. STREET ADDRESS <p style="text-align: center;">67X-3</p>	
<b>3. NAME OF DECEASED</b> (Type or print) <p style="text-align: center;">Frank Leroy MacCrea</p>		<b>4. DATE OF DEATH</b> Month Day Year <p style="text-align: center;">November 17 1961</p>	
<b>5. SEX</b> <p style="text-align: center;">Male</p>	<b>6. COLOR OR RACE</b> <p style="text-align: center;">White</p>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <p style="text-align: center;">October 23, 1907</p>
<b>9. AGE</b> (In years last birthday) <p style="text-align: center;">54 yrs.</p>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min. 	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <p style="text-align: center;">Machinist</p>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <p style="text-align: center;">Not employed</p>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <p style="text-align: center;">New Jersey</p>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <p style="text-align: center;">U.S.A.</p>	
<b>13. FATHER'S NAME</b> <p style="text-align: center;">James MacCrea</p>		<b>14. MOTHER'S MAIDEN NAME</b> <p style="text-align: center;">Bertha Capwell</p>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <p style="text-align: center;">no</p>		<b>16. SOCIAL SECURITY NO.</b> <p style="text-align: center;">148-07-6969</p>	
<b>17. INFORMANT</b> Address <p style="text-align: center;">The Medical Record The Clinical Center, Bethesda 14, Maryland</p>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <p style="text-align: center;">Mycosis fungoides, extensive</p> DUE TO (b) <p style="text-align: center;">Pneumonia, Left upper lobe</p> DUE TO (c) <p style="text-align: center;">Multiple abscesses, colon</p>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <p style="text-align: center;">2 1/2 years</p>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <p style="text-align: center;">19</p>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State) <p style="text-align: center;">Aug. 19 1961, to Nov. 17 1961</p>
<b>21. I certify</b> that (X) (this hospital) attended the deceased from ..... 1961, to ..... 1961, that (X) (we) last saw the deceased alive on ..... Nov. 17 1961, and that death occurred at 5:40 AM on the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <p style="text-align: center;">John C. Marsh</p>		<b>22b. DATE SIGNED</b> <p style="text-align: center;">November 17, 1961</p>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <p style="text-align: center;">John C. Marsh, M.D.</p>		<b>22d. ADDRESS</b> <p style="text-align: center;">The Clinical Center, National Institutes of Health, Bethesda 14, Md.</p>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <p style="text-align: center;">BURIAL</p>		<b>23b. DATE THEREOF</b> <p style="text-align: center;">11/17/61</p>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <p style="text-align: center;">W.W. Chambers Co. Washington D.C.</p>		<b>23d. LOCATION</b> (City, town or county) (State) <p style="text-align: center;">BELLMAWR N.T.</p>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <p style="text-align: center;">W.W. Chambers Co. Washington D.C.</p>		<b>25a. REC'D BY REGISTRAR</b> DATE <p style="text-align: center;">NOV 24 '61</p>	
<b>25b. REGISTRAR'S SIGNATURE</b> <p style="text-align: center;">Arthur S. Kraus</p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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## CERTIFICATE OF DEATH

Reg. Dist. No. 12835

12849

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Laytonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>01 Rural - Laytonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Riggs Rd.</b>		d. STREET ADDRESS <b>1 Riggs Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>ANGUS</b> Middle <b>(none)</b> Last <b>MACLEAN</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 16, 1871</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business - automotive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automotive</b>	
11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Murdoch MacLean</b>		14. MOTHER'S MAIDEN NAME <b>unknown.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>380-22-2865</b>	
17. INFORMANT <b>Mrs. Ray Roberts</b> Address <b>Derwood, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 yrs.</b> <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. n.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 31</b> , 19 <b>61</b> , to <b>Nov 2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Oct 31</b> , 19 <b>61</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard A. Yates</b> M.D.		ADDRESS (Street, city or town, state) <b>Olney, Md.</b> DATE SIGNED <b>11/2/61</b>	
PHYSICIAN'S NAME (Type) <b>Richard A. YATES</b>		<b>Olney, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/4/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 6 '61</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12850 CERTIFICATE OF DEATH 12836											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MANASSAS</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b> d. STREET ADDRESS <b>51 MERRYMAN STREET</b>						
3. NAME OF DECEASED (Type or print) <b>MELVIN EUGENE MAKLE</b>					4. DATE OF DEATH Month Day Year <b>11 22 19 61</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/20/61</b>		9. AGE (In years last birthday) <b>2 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MONTGOMERY, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>RAYMOND WILLIAM MAKLE</b>					14. MOTHER'S MAIDEN NAME <b>LAURA VIRGINIA DORSEY</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>-</b>					17. INFORMANT <b>HOSPITAL RECORDS</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPOPROTHROMBINEMIA, CONGENITAL.</b> 771.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>-</b> (a), stating the underlying cause last. DUE TO (c) <b>-</b>									INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>			20c. TIME OF INJURY Month, Day, Year <b>11 22 19 61</b> Hour a.m. p.m. <b>1:45P</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>			20f. (City or town) <b>ELLICOTT CITY</b>			(County) <b>MONTGOMERY</b>			(State) <b>MARYLAND</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>11/20/61</b> to <b>11/22/61</b> , that (I) (we) last saw the deceased alive on <b>11/22/61</b> , and that death occurred at <b>1:45P</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Charles S. Whitaker</b>					22b. DATE SIGNED <b>11/22/61</b>						
22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>					22d. ADDRESS <b>CARLISLE, MARYLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (Type) <b>Burial</b>			23b. DATE THEREOF <b>11/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Locust Methodist.</b>			23d. LOCATION (City, town or county) (State) <b>Simpsonville, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>					ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 29 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		

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CERTIFICATE OF DEATH

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CHARLES S. WINTER, JR.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Michigan</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Marylander Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Grace Gertrude Martin</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>16</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 29, 1879</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Norman W. Hine</b>				14. MOTHER'S MAIDEN NAME <b>Laura Fletcher</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mr. David Bishop</b>				Address <b>2605 Elmont Street Silver Spring, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.11 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>16 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 10, 1960</b> to <b>Nov. 16, 1960</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>Nov. 15, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>James P. Kerr</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>				22d. ADDRESS <b>Damascus, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>11/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CREMATORY</b>		23d. LOCATION (City, town or county) (State) <b>PRINCE' GEORGE'S COUNTY MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner P. Pumphrey</b>				25a. REC'D BY REGISTRAR <b>NOV 20 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12852

## CERTIFICATE OF DEATH

12838

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6201 Green Tree Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>45 Bethesda</b> d. STREET ADDRESS <b>6201 Green Tree Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GLADYS A McALLISTER</b>		4. DATE OF DEATH <b>Nov. 24, 1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/25/1887</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Operator-Tel. Co.-in Nebraska</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John A. Peugh</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Hurlbutt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>505-07-0467</b>	
17. INFORMANT <b>G. Belva Anderson</b>		Address <b>6201 Green Tree Rd. Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROBABLE MYOCARDIAL INFARCTION 2 HRS</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>10-23-1961</b> to <b>11-24-1961</b> that (I) <del>(the hospital)</del> last saw the deceased alive on <b>11-23-1961</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward Lewis Jr.</b> M.D.		22b. DATE SIGNED <b>11-24-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD LEWIS, JR. M.D.</b>		22d. ADDRESS <b>5800 BEECH AVE, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>11/27/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>--</b>		23d. LOCATION (City, town or county) (State) <b>Litchfield, Nebraska</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.-2901 14th St. N.W. Washington 9, D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12833

12839

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>83X-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Virginia Beach</u> d. STREET ADDRESS <u>177 Pinewood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Clara</u> Middle <u>Wilhelmina</u> Last <u>McCully</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>17</u> Year <u>1961</u>		<b>5. SEX</b> <u>Female</u>			
<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MARCH 28, 1900</u> <b>9. AGE</b> (In years last birthday) <u>60 yrs.</u> <b>IF UNDER 1 YEAR</b> Months <u>04</u> Days <u>04</u> <b>IF UNDER 24 HRS.</b> Hours <u>04</u> Min. <u>04</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Norfolk, VA</u>			
<b>13. FATHER'S NAME</b> <u>Max Moser</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>American</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Washington Sanitarium and Hospital Records</u> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>4-20-1</u> (c) <u>4-5-1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4-5-1</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Nov 14, 1961</u> to <u>Nov 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 16, 1961</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>W.B. Wardrop MD</u>		<b>22b. DATE SIGNED</b> <u>11/17/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W.B. WARDROP MD</u>			
<b>22d. ADDRESS</b> <u>800 Pershing Dr. Belvoir Spring Md.</u>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>					
<b>23b. DATE THEREOF</b> <u>Nov 18, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Crematory</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Prince George Co. Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey Inc</u>		<b>24b. ADDRESS</b> <u>8434 Georgia Ave Sil.Sp. Md</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Hanna</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>		<b>25c. DATE</b> <u>NOV 22 '61</u>					

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12854

12840

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Falls Church</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY in lb <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>6400 Glen Forest Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Patrick Henry Mc Grath</b>		4. DATE OF DEATH <b>November 21 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-2-70</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Mc Grath</b>		14. MOTHER'S MAIDEN NAME <b>Anastasia Dooley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>6400 Glen Forest Dr., Falls Church</b>	
17. INFORMANT <b>Mrs. Mary C. McGrath, Virginia</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebro-Vascular Thrombosis</b> DUE TO (c) <b>48-72 hrs</b> 48-72 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Previous episodes of Cerebro-Vascular Thrombosis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 18 1961</b> to <b>November 21 1961</b> (x) (we) last saw the deceased alive on <b>November 21 1961</b> and that death occurred at <b>4:00 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William A. Rack</b> M.D.		22b. DATE SIGNED <b>November 22, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>William A Rack LT MC USN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-24-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Fairfax, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert F. Murphy</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. ADDRESS <b>13324 Columbia Pike Arlington, Virginia</b>	

13840

13840



John Wilson

days

2 months (over)

2 00 Jan 1900

2 00 Jan 1900

November 21

Henry to Wash

later

2-2-77

Wash 1900

U.S.A.

New York

Illinois

Chicago

Amesbury, Mass

Amesbury, Mass

Wm. A. Smith, Esq.,  
Care of Dr. J. P. Jones,  
Amesbury, Mass.

Wm

Wm. A. Smith, Esq.,  
Care of Dr. J. P. Jones,  
Amesbury, Mass.

Wm. A. Smith, Esq.,  
Care of Dr. J. P. Jones,  
Amesbury, Mass.

Wm. A. Smith, Esq.,  
Care of Dr. J. P. Jones,  
Amesbury, Mass.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12855

12841

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN lb <u>65 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> d. STREET ADDRESS <u>30 Ancell Street</u>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Kenneth</u> <u>(n)</u> <u>McKay</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>21</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Caucasian</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>									
<b>8. DATE OF BIRTH</b> <u>September 22, 1913</u>		<b>9. AGE</b> (In years last birthday) <u>48</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Armed Forces</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Armed Forces</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U. S. Navy</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Massachusetts</u>									
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Harry W. McKay</u>											
<b>14. MOTHER'S MAIDEN NAME</b> <u>Louise Loud</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II Korea</u> <u>017 03 8017</u>											
<b>16. SOCIAL SECURITY NO.</b> <u>017 03 8017</u>		<b>17. INFORMANT</b> Address <u>WIFE: Elizabeth S. McKay, Same as #2</u>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma involving large bowel</u> DUE TO (b) <u>with bowel obstruction &amp; hemorrhage</u> DUE TO (c) <u>Carcinoma Kidney</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m.      p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County)      (State) <u>Sept. 18, 1961, to Nov. 21, 1961</u>													
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 18, 1961</u> , to <u>Nov. 21, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 21, 1961</u> , and that death occurred at <u>12:31 AM</u> from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>H. S. Irons</u> M.D.				<b>22b. DATE SIGNED</b> <u>November 21 1961</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>H. S. IRONS LT MC USN</u>				<b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11-24-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>									
<b>23d. LOCATION</b> (City, town or county)      (State) <u>Arlington, Va.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Alfred F. Burns</u> <u>Cunningham Funeral Home Inc. Cameron &amp; Alfred Sts.</u>											
<b>25a. REC'D BY REGISTRAR</b> <u>NOV 24 61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thayer</u>											

12341

CERTIFICATE OF DEATH

12341



NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12842

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>12 Rockville</u> d. STREET ADDRESS <u>13415 Carroll Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. Norman Elmer McKenzie</u>		4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-06</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTEMPO ASSC.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Noah McKenzie</u>		14. MOTHER'S MAIDEN NAME <u>Inez Minnick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>			
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 578X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Surgery - Rectum</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 35, 1961</u> to <u>Nov 26, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 26, 1961</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Robert A. Hare</u> M.D.		22b. DATE SIGNED <u>11/26/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>		22d. ADDRESS <u>7600 Carroll Ave T. Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/30/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>ST MICHAEL'S</u>		23d. LOCATION (City, town or county) (State) <u>FROSTBURG MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantsville, MD</u>		25a. REC'D BY REGISTRAR <u>DEC 4 '61</u>			
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hare</u>			

1881

1881

(M)

Montgomery

Town Park

Washington St. & 1st St. Carroll Ave.

Mr. Norman & Edward McKean

Male White

1881-82

Cabinet Maker - 1st St. & 1st St.

North McKean

1st St. & 1st St.  
Hospital Records

No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12857

## CERTIFICATE OF DEATH

12843

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>45 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Erwin</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route # 1</b> d. STREET ADDRESS <b>70X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Burnice Edward McKoy</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>4</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>December 6, 1938</b> <b>22</b> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Unknown</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>North Carolina</b>
<b>13. FATHER'S NAME</b> <b>Herman McKoy</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Susan M. Morris</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>17. INFORMANT</b> <b>The Medical Record</b> <b>Unascertainable: The Clinical Center, Bethesda 14, Maryland</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive leukemic pericarditis</b> DUE TO (c) <b>Acute lymphocytic leukemia</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>24 hours</b> <b>4 days</b> <b>3 months</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State) <b>September 20, 1961</b> <b>November 4, 1961</b> <b>12:50 p.m.</b>
<b>21. I certify that</b> (X) (this hospital) attended the deceased from <b>September 20, 1961</b> to <b>November 4, 1961</b> , that (X) (we) last saw the deceased alive on <b>November 4, 1961</b> , and that death occurred at <b>12:50 p.m.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Edward S. Henderson</b> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <b>Edward S. Henderson</b>		<b>22b. DATE SIGNED</b> <b>November 6, 1961</b> <b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>11-7-61</b>	<b>23b. DATE THEREOF</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Dunn North Carolina</b>
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Frazier's Funeral Home Inc</b> ADDRESS <b>389-R.D. Ave. N.W.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 8 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Henderson</b>	

15813

15813



North Carolina

North Carolina

1914

1914

1914

Route 1

The Clinical Center, Bethesda 14, Md.

1914

1914

1914

December 6, 1914

1914

U.S.A.

North Carolina

Unknown

Factory Worker

Queen A. Morris

Queen Morris

Unsubstantiated the Clinical Center, Bethesda 14, Maryland

No

active in the field

active in the field

September 20, 1914

November 1, 1914

The Clinical Center, Bethesda 14, Md.  
Institution of Health, Bethesda 14, Md.

1914



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12858  
CERTIFICATE OF DEATH  
12844

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crestview</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>56 Crestview</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4901 Crescent Street</b>				d. STREET ADDRESS <b>4901 Crescent Street</b>			
3. NAME OF DECEASED (Type or print) <b>Annie Irene McMullen</b>				4. DATE OF DEATH <b>Nov. 21 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/26/1879</b>	
9. AGE (in years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>23</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles Croson</b>				14. MOTHER'S MAIDEN NAME <b>Eugene Lynn</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edith Robey-daughter-same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Breast - Generalized Metastases.</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis &amp; Hypertension</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19 <b>50</b> , to <b>11/21</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/21</b> , 19 <b>61</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>S. A. Thomas MD</b>				22b. DATE SIGNED <b>11/21/61</b>		22c. PHYSICIAN'S NAME (Type) <b>S. A. Thomas MD</b>	
22d. ADDRESS <b>4301 48th St. N.W. Wash D.C.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nat. Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Falls Church, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>NOV 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Robert S. Thomas</b>	

(M)

1

Robert A. Ramsey, Bethesda, Maryland  
11/25/61 Nat. Memorial Park

Salis Church, Virginia

11/21/61



18815

12873

Montgomery

Bedford

Bedford

Bedford

Bedford

(Springfield)

Springfield and Bedford

21

30

Nov.

Mass.

F.

1880

60

Mar. 21, 1875

White

Female

Housewife

Washington, D. C.

U. S. A.

James M. Thompson

Joseph Thompson

2257 Washington Ave.

Bedford, Mass.

none

(Springfield)

Washington, D. C.

Old Hill Cemetery

18815

Bedford

The S. H. Hines Co. Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
12860															
12846															
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN It <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7213 Beacon Terrace</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>60 Bethesda</b> d. STREET ADDRESS <b>7213 Beacon Terrace</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Louise</b>			First <b>Meyer</b>			Middle <b>Meyer</b>			Last <b>Meyer</b>			4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 15, 1886</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b>		IF UNDER 24 HRS. Hours <b>13</b> Min. <b>19</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Dietrich Plate</b>						14. MOTHER'S MAIDEN NAME <b>Anna Lange</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Anna M. Woke, daughter-same 2d</b> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardio-respiratory failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebral vascular accident</b> DUE TO (c) <b>arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>5 days</b> <b>15 yrs.</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bethesda</b>		(County) <b>Montgomery</b>		(State) <b>Maryland</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 13, 1961</b> to <b>Nov 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 13, 1961</b> , and that death occurred at <b>5:29 P.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>John M. Wyman</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>14 Nov 61</b>						
22c. PHYSICIAN'S NAME (Type) <b>John M. Wyman</b>						22d. ADDRESS <b>Bethesda, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bethesda, Robert A. Pumphrey, Maryland</b> ADDRESS						25a. REC'D BY REGISTRAR <b>NOV 16 '61</b> DATE			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>						

(M)

13700

13700

Montgomery

Montgomery

Montgomery

Bethesda

Bethesda

2013 Beacon Terrace

2013 Beacon Terrace

Louis

Louis

November 12 1985

Jan. 15 1986

White

Georgia

USA

Honolulu

District Plaza

Anna Lane

Ann H. Lane, daughter-age 24

None

No

Bethesda, Maryland

John H. Ryan

Bethesda, Maryland

Rockville, Maryland

11/15/85

Special

Bethesda, Robert A. Emery, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

121

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74

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# STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12861

## CERTIFICATE OF DEATH

12847

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Samuel A. Miller</u>		<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>21</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept 28 1907</u>
<b>9. AGE</b> (In years last birthday) <u>54</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>12a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Actuary</u>		<b>12b. KIND OF BUSINESS OR INDUSTRY</b> <u>Permanently</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Miller</u>		<b>14. MOTHER'S M maiden name</b> <u>Fannie ?</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>World War II</u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Lillian Miller (wife)</u>		<b>18. ADDRESS</b> <u>(Same as above)</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hours</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>August 1954</u> <b>to</b> <u>Nov. 21, 1961</u> , that (I) <u>we</u> last saw the deceased alive on <u>Nov. 21, 1961</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Stephen C. Cromwell</u> M.D.		<b>22b. DATE SIGNED</b> <u>11/24/61</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>STEPHEN C. CROMWELL</u>		<b>22d. ADDRESS</b> <u>615 W. Montgomery Ave, Rockville, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE HEREOF</b> <u>11-24-61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>NEW MONTEFIORE CEM.</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>NEW YORK</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>BERNARD DANZANSKY &amp; SONS</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 24 61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>		<b>25c. ADDRESS</b> <u>3501 14th St. NW</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

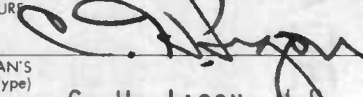
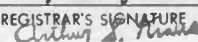
VR A15 (4)  
ISM 9/59

STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12862

CERTIFICATE OF DEATH

12848

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>1 DAY</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			d. STREET ADDRESS <b>Rt. 1</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>ROSIER</b> Middle <b>LEE</b> Last <b>MILLS</b>			4. DATE OF DEATH Month <b>11</b> Day <b>3</b> Year <b>19 61</b>			5. SEX <b>MALE</b>			6. COLOR OR RACE <b>WHITE</b>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>6/7/00</b>			9. AGE (In years lost birthday) <b>61</b> yrs.			10. IF UNDER 1 YEAR Months <b>11</b> Days <b>3</b> Hours <b>19</b> Min. <b>61</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NIGHT WATCHMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SAND &amp; GRAVEL CO.</b>			11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>GEORGE MILLS</b>			14. MOTHER'S MAIDEN NAME <b>ROSIE WILLIAMS</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b>			16. SOCIAL SECURITY NO. <b>218-12-6036</b>			17. INFORMANT <b>HOSPITAL RECORDS</b>			Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHOLEMIC NEPHROSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LIPOSARCOMA, RETROPERITONEAL, WITH METASTASES</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>---</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>			20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (the hospital) attended the deceased from <b>OCTOBER 5 1961</b> to <b>NOVEMBER 3 1961</b> , that (I) (we) last saw the deceased alive on <b>NOV. 3 19 61</b> and that death occurred at <b>9:40A</b> , from the causes and on the date stated above.																							
22a. SIGNATURE 			22b. DATE SIGNED <b>11/3/61</b>			22c. PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M.D.</b>			22d. ADDRESS <b>SANBY SPRING, MARYLAND</b>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. DATE SIGNED <b>11/3/61</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11/7/61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Union</b>			23d. LOCATION (City, town, or county) (State) <b>Burtonsville, Maryland</b>			24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b>			25a. REC'D BY REGISTRAR <b>NOV 6 1961</b>			25b. REGISTRAR'S SIGNATURE 					

(M)

158-18

DEPARTMENT OF HEALTH

1945

REPORT OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

OTHER CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12863 CERTIFICATE OF DEATH 12849

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maine</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Thelma</b>	
c. LENGTH OF STAY in lb <b>5 days</b>		d. STREET ADDRESS <b>17 Clifton Rd. 57X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Roland Banks Moore</b>		4. DATE OF DEATH Month Day Year <b>November 10 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1886</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William S. Moore</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Toner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WW I WW II</b>		16. SOCIAL SECURITY NO. <b>005-42-8684</b>	
17. INFORMANT <b>WIFE: Anna A. Moore Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>indet.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Uremia</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6 November, 1961</b> to <b>10 November 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10 November 1961</b> , and that death occurred at <b>09:50 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. W. Brackett</b>		22b. DATE SIGNED <b>11-11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. W. BRACKETT LT MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>11-11-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Portland, Maine</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ronaldi Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 15 '61</b>	
ADDRESS <b>816 H. St. N.E. Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Lincoln S. Kline</b>	

12842

CERTIFICATE OF DEATH

12842

(M)

Name

Name

Age

(1-2-3)

Sex

Sex

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Date of Birth

Date of Birth

Date of Birth

Age

Age

Age

Age

Place of Death

Place of Death

Time of Death

Time of Death

Time of Death

Time of Death

Signature of Physician

Witness

Date of Death

Date of Death

11-11-11

11-11-11

Signature

U.S. Social Security Administration

U.S. Social Security Administration

Port of Birth

Port of Birth

Port of Birth

U.S. Social Security Administration



1

12864

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12850  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Footesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Footesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>WILLIAM</u> <u>Middle</u> <u>H.</u> <u>Lost</u> <u>MOORE</u>		4. DATE OF DEATH <u>November 24</u> 19 <u>61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Moore</u>		14. MOTHER'S MAIDEN NAME <u>Annie Gault</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Gertrude Harper. Footesville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>acute congestive heart failure</u> DUE TO (b) <u>cardiac hypertrophy</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>10 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, marked.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 1950</u> to <u>Nov 24, 1961</u> , that I last saw the deceased alive on <u>Nov 22 1961</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Lawrence</u> M.D.		ADDRESS (Street, city or town, state) <u>P.O. Bay D.S. Md.</u> DATE SIGNED <u>11/24/61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-28-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jerusalem Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Footesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HO... ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1881

1881

1881

- Mr. Lee.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G301 11/22/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No.

12851

12865

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>3 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookgrove Foundation</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laytonsville</u> d. STREET ADDRESS <u>10 Olney, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Calvin W. Mullinix</u>				4. DATE OF DEATH <u>Nov. 14 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 19 1876</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer Store Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>		11. BIRTHPLACE (State or foreign country) <u>Montg. Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>							
13. FATHER'S NAME <u>James L. Mullinix</u>				14. MOTHER'S M maiden NAME <u>Mary Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-32-1144</u>		17. INFORMANT <u>J. Carlton Mullinix, Olney, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>5 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/13/61</u> to <u>11/14/61</u> , that I last saw the deceased alive on <u>11/13/61</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. L. [Signature]</u>				ADDRESS (Street, city or town, state) <u>Damascus, Md.</u> DATE SIGNED <u>11/14/61</u>			
PHYSICIAN'S NAME (Type) <u>C. H. L. [Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. L. [Signature]</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 17 '61</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1905

1905

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of death: <i>Jan 15 1905</i></p>	
<p>5. Place of death: <i>Home</i></p>		<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>[Signature]</i></p>		<p>8. Signature of registrar: <i>[Signature]</i></p>	
<p>9. Name of registrar: <i>John Doe</i></p>		<p>10. Address of registrar: <i>123 Main St</i></p>	
<p>11. Name of informant: <i>John Doe</i></p>		<p>12. Address of informant: <i>123 Main St</i></p>	
<p>13. Name of informant: <i>John Doe</i></p>		<p>14. Address of informant: <i>123 Main St</i></p>	
<p>15. Name of informant: <i>John Doe</i></p>		<p>16. Address of informant: <i>123 Main St</i></p>	
<p>17. Name of informant: <i>John Doe</i></p>		<p>18. Address of informant: <i>123 Main St</i></p>	
<p>19. Name of informant: <i>John Doe</i></p>		<p>20. Address of informant: <i>123 Main St</i></p>	
<p>21. Name of informant: <i>John Doe</i></p>		<p>22. Address of informant: <i>123 Main St</i></p>	
<p>23. Name of informant: <i>John Doe</i></p>		<p>24. Address of informant: <i>123 Main St</i></p>	
<p>25. Name of informant: <i>John Doe</i></p>		<p>26. Address of informant: <i>123 Main St</i></p>	
<p>27. Name of informant: <i>John Doe</i></p>		<p>28. Address of informant: <i>123 Main St</i></p>	
<p>29. Name of informant: <i>John Doe</i></p>		<p>30. Address of informant: <i>123 Main St</i></p>	
<p>31. Name of informant: <i>John Doe</i></p>		<p>32. Address of informant: <i>123 Main St</i></p>	
<p>33. Name of informant: <i>John Doe</i></p>		<p>34. Address of informant: <i>123 Main St</i></p>	
<p>35. Name of informant: <i>John Doe</i></p>		<p>36. Address of informant: <i>123 Main St</i></p>	
<p>37. Name of informant: <i>John Doe</i></p>		<p>38. Address of informant: <i>123 Main St</i></p>	
<p>39. Name of informant: <i>John Doe</i></p>		<p>40. Address of informant: <i>123 Main St</i></p>	
<p>41. Name of informant: <i>John Doe</i></p>		<p>42. Address of informant: <i>123 Main St</i></p>	
<p>43. Name of informant: <i>John Doe</i></p>		<p>44. Address of informant: <i>123 Main St</i></p>	
<p>45. Name of informant: <i>John Doe</i></p>		<p>46. Address of informant: <i>123 Main St</i></p>	
<p>47. Name of informant: <i>John Doe</i></p>		<p>48. Address of informant: <i>123 Main St</i></p>	
<p>49. Name of informant: <i>John Doe</i></p>		<p>50. Address of informant: <i>123 Main St</i></p>	
<p>51. Name of informant: <i>John Doe</i></p>		<p>52. Address of informant: <i>123 Main St</i></p>	
<p>53. Name of informant: <i>John Doe</i></p>		<p>54. Address of informant: <i>123 Main St</i></p>	
<p>55. Name of informant: <i>John Doe</i></p>		<p>56. Address of informant: <i>123 Main St</i></p>	
<p>57. Name of informant: <i>John Doe</i></p>		<p>58. Address of informant: <i>123 Main St</i></p>	
<p>59. Name of informant: <i>John Doe</i></p>		<p>60. Address of informant: <i>123 Main St</i></p>	
<p>61. Name of informant: <i>John Doe</i></p>		<p>62. Address of informant: <i>123 Main St</i></p>	
<p>63. Name of informant: <i>John Doe</i></p>		<p>64. Address of informant: <i>123 Main St</i></p>	
<p>65. Name of informant: <i>John Doe</i></p>		<p>66. Address of informant: <i>123 Main St</i></p>	
<p>67. Name of informant: <i>John Doe</i></p>		<p>68. Address of informant: <i>123 Main St</i></p>	
<p>69. Name of informant: <i>John Doe</i></p>		<p>70. Address of informant: <i>123 Main St</i></p>	
<p>71. Name of informant: <i>John Doe</i></p>		<p>72. Address of informant: <i>123 Main St</i></p>	
<p>73. Name of informant: <i>John Doe</i></p>		<p>74. Address of informant: <i>123 Main St</i></p>	
<p>75. Name of informant: <i>John Doe</i></p>		<p>76. Address of informant: <i>123 Main St</i></p>	
<p>77. Name of informant: <i>John Doe</i></p>		<p>78. Address of informant: <i>123 Main St</i></p>	
<p>79. Name of informant: <i>John Doe</i></p>		<p>80. Address of informant: <i>123 Main St</i></p>	
<p>81. Name of informant: <i>John Doe</i></p>		<p>82. Address of informant: <i>123 Main St</i></p>	
<p>83. Name of informant: <i>John Doe</i></p>		<p>84. Address of informant: <i>123 Main St</i></p>	
<p>85. Name of informant: <i>John Doe</i></p>		<p>86. Address of informant: <i>123 Main St</i></p>	
<p>87. Name of informant: <i>John Doe</i></p>		<p>88. Address of informant: <i>123 Main St</i></p>	
<p>89. Name of informant: <i>John Doe</i></p>		<p>90. Address of informant: <i>123 Main St</i></p>	
<p>91. Name of informant: <i>John Doe</i></p>		<p>92. Address of informant: <i>123 Main St</i></p>	
<p>93. Name of informant: <i>John Doe</i></p>		<p>94. Address of informant: <i>123 Main St</i></p>	
<p>95. Name of informant: <i>John Doe</i></p>		<p>96. Address of informant: <i>123 Main St</i></p>	
<p>97. Name of informant: <i>John Doe</i></p>		<p>98. Address of informant: <i>123 Main St</i></p>	
<p>99. Name of informant: <i>John Doe</i></p>		<p>100. Address of informant: <i>123 Main St</i></p>	

TO BE SIGNED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO BE SIGNED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12866					12852				
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NAS Patuxent River				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital					d. STREET ADDRESS 710E MEMQ				
3. NAME OF DECEASED (Type or print) Charles Edward Murphy Sr.					4. DATE OF DEATH Month Day Year November 14, 1961				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1899		9. AGE (In years last birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Patrick Murphy	
14. MOTHER'S MAIDEN NAME Sarah (Unknown)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 167 03 0811		17. INFORMANT Address SON Charles Edward Murphy Jr., Same as #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cerebrum, metastatic to liver DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 25, 1961, to November 14, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 14, 1961, and that death occurred at 12:28 PM from the causes and on the date stated above.		22a. SIGNATURE John W. Brackett, Jr. M.D.	
22b. DATE SIGNED November 14, 1961		22c. PHYSICIAN'S NAME (Type) JOHN W. BRACKETT JR. LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Shipment		23b. DATE THEREOF 11-15-61	
23c. NAME OF CEMETERY OR CREMATORY Plum Creek Cemetery, New Texas, Pennsylvania		23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, 8434 Georgia Ave., Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE NOV 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. House	

1888

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*[Handwritten signature]*



TO SPIRITUAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 23b, Film G301 11/30/61 iwk

12853

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>✓</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
c. LENGTH OF STAY IN lb <b>78 days</b>			d. STREET ADDRESS <b>2101 Connecticut Avenue</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>William John Murphy</b>			4. DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>1961</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>Caucasian</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Aug. 29, 1897</b>		
9. AGE (In years last birthday) <b>64 yrs.</b>			10. IF UNDER 1 YEAR Months <b>64</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Naval Officer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William Thomas Murphy</b>			14. MOTHER'S MAIDEN NAME <b>Nora Graney</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWII</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		
17. INFORMANT <b>Hospital Records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Bladder</b> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that <b>xx</b> (this hospital) attended the deceased from <b>Sept. 7, 1961</b> to <b>Nov. 23, 1961</b> , that <b>(x)</b> (we) last saw the deceased alive on <b>Nov. 23, 1961</b> , and that death occurred at <b>11:45 PM</b> the causes and on the date stated above. 22a. SIGNATURE <b>William C. Monell</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>WILLIAM C. MONELL, LT MC USN</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b> 22b. DATE SIGNED <b>November 24, 1961</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11/28/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b> 23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawlers Sons Inc.</b> 25a. REC'D BY REGISTRAR <b>NOV 27 '61</b> 25b. REGISTRAR'S SIGNATURE <b>William S. Thoma</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 12854

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>11/3/61</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea Woodland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>G.</u> Last <u>Myers</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>6<sup>th</sup></u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>London County, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James B. Furtney</u>		14. MOTHER'S MAIDEN NAME <u>Susan Virts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>547-09-34720</u>	
17. INFORMANT <u>Susan M. Maher, Daughter</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Phlebotrombosis</u> (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>3-4 days</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus - Acidosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> to <u>Nov 6, 1961</u> , that I last saw the deceased alive on <u>Nov 6, 1961</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Grey</u>		ADDRESS (Street, city or town, state) <u>7105 Riggs Pl. Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT B. GREY</u>		DATE SIGNED <u>Nov 6, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/9/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home, Inc.</u>		ADDRESS <u>4th. Rainier Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

1885

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*[Faint, mostly illegible text, likely a death certificate form with fields for name, age, sex, cause of death, etc.]*

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12869

12855

<b>PLACE OF DEATH</b> a. COUNTY <u>Montgomery County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>Carroll Hall Sanitarium</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Hall Sanitarium</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>5031 -5th Street N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ESTELLE</u> Middle <u>VERNAY</u> Last <u>MYERS</u>		<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>1</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov 14th 1874</u>
<b>9. AGE</b> (In years last day) <u>86</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John Vernay</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Wright</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	
<b>17. INFORMATION</b> <u>Hospital Records-10231</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> (b) <u>ESSENTIAL HYPERTENSION</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>SENILITY</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>MAY 15, 1960</u> , to <u>Nov. 1st, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov. 1st, 1961</u> , and that death occurred <u>6:30 PM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Henry M. Lowden</u>		<b>22b. DATE SIGNED</b> <u>NOV. 1-1961</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Henry M. Lowden</u>		<b>22d. ADDRESS</b> <u>3206 NORWAY DR. CHEVY CHASE, MD.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/4/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Fredrick, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S. H. Smith Co., 2901 14th St NW</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 3 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>			

TO FURNISH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12856

12870

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - SILVER SPRING, MD.</b> c. LENGTH OF STAY IN 1b <b>Since</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>LE DEAU-GARDENS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTG.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER-SPRING, MD.</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BLANCHE - PARKER - NELSON</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19 - 1898</b> 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sort - Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Wash. D.C.</b>
13. FATHER'S NAME <b>Thos. J. Parker</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Kenney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>7323</b>	
17. INFORMANT <b>Wm. P. Long</b>		Address <b>Lakewood Pk. Hl.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension, Etiology Unknown</b> 332X DUE TO (b) <b>Repeated Cerebral Thromboses.</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <b>48 hrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sep. 1961</b> to <b>Oct. 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>Oct. 31, 1961</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert T. Thibadeau</b> M.D.		22b. DATE SIGNED <b>Nov 1 - 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT T. THIBADEAU</b>		22d. ADDRESS <b>10606 CONCORD ST. KENS., MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 4 - 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Washington - D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walter</b>		25a. REC'D BY REGISTRAR <b>NOV 6 '61</b>	
ADDRESS <b>254 Carroll St. NW D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Item 14 Film G301 11/20/61 iwk

TO LOCAL MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6605 Wilson Lane</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>6605 Wilson Lane</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Eldon Ferdinand Nelson</u>		<b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>12</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>12-11-1900</u>		<b>9. AGE</b> (In years last birthday) <u>60 yrs.</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Asst Sup.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Dept of Cor.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Mass</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.C</u>		<b>13. FATHER'S NAME</b> <u>Alford Nelson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> Address <u>Miriam E. Nelson - Stm 2</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>11-12-61</u>			
<b>EXAMINER'S NAME</b> (Type) <u>FRANK J. BROSCHE</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <u>  </u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>  </u>		<b>22b. DATE THEREOF</b> <u>11/17/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Crematory</u>			
<b>22d. LOCATION</b> (City, town, or country) <u>Pr. Geo. Co., Maryland</u>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR</b> <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		<b>ADDRESS</b> <u>Wash, D.C.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>NOV 14 '61</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hanna</u>							

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FOR THE  
BUREAU OF  
THE  
UNITED STATES  
DEPARTMENT OF  
AGRICULTURE

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

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VS. A15ME  
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TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12872

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12858

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 hrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>36 Kensington</i>		d. STREET ADDRESS <i>3423 Nimitz Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington San &amp; Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Leigh Lanman Nettleton</i>				4. DATE OF DEATH Month <i>Nov</i> Day <i>13</i> Year <i>1961</i>			
5. SEX <i>Male</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-14-46</i>	9. AGE (In years last birthday) <i>14 yrs</i>	IF UNDER 1 YEAR Months <i>14</i> Days <i>13</i> Hours <i>19</i> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School boy</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>etc.</i>		11. BIRTHPLACE (State or foreign country) <i>N.S.A</i>		12. CITIZEN OF WHAT COUNTRY? <i>N.S.A</i>	
13. FATHER'S NAME <i>Leigh L. Nettleton, Jr.</i>				14. MOTHER'S MAIDEN NAME <i>Dollie C Nettleton</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Parents -</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive inter thoracic hemorrhage</i> DUE TO (b) <i>Complete separation 11+12 dorsal vertebrae</i> DUE TO (c) <i>Struck by auto</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>812 X</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>LACERATION OF LIVER AND FRACTURE LEFT FEMUR.</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Pedestrian - struck by auto</i>					
20c. TIME OF INJURY Month, Day, Year <i>4:40 p.m. 11-13 1961</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>street</i>		20f. (City or town) (County) (State) <i>Wheaton montg md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschert</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>11-14-61</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <i>Washington D.C.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/17/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR <i>Raymond A. Ziska</i>		ADDRESS <i>8434 GEORGIA AVENUE</i>		24a. REC'D BY REGISTRAR <i>NOV 16 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	
WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND							



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Leah C Nettleton

Leah C Nettleton

Leah C Nettleton



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 12, MARYLAND  
12873

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b. <b>8 hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. NAVAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D.C.</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47x-3</b> d. STREET ADDRESS <b>1901 23rd Street, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Twin-A Baby Girl Nicles</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 11, 1961</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	9. AGE (In years last birthday) yrs. <b>27</b> IF UNDER 1 YEAR Months Days <b>40</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clayton E. Nicles</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Mae Rinehart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Clayton E. Nicles</b>		Address <b>1901 23rd St., S.E. Wash. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity (1 lb 3 oz)</b> DUE TO <b>776X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs 40 min</b>
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>11 November, 1961</b> , to <b>11 November 19 61</b> that <b>11</b> (we) last saw the deceased alive on <b>11 November 19 61</b> , and that death occurred at <b>06:25 PM</b> from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE <b>M.C. OBANNON JR.</b> M.D.		22b. DATE SIGNED <b>11-11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.C. OBANNON JR. LT MC USN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-14-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Gaithersburg, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> <b>Tyson Wheeler Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 14 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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(11-11-11)

U.S. DEPARTMENT OF JUSTICE

Division of Investigation

November 11, 1934

Washington, D.C.

Mr. J. Edgar Hoover, Director

Chicago, Illinois

November 11, 1934

11-11-34

U.S. DEPARTMENT OF JUSTICE

Division of Investigation

November 11, 1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>8 hrs 40min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. NAVAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Maryland-D.C.</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>478-3</b> d. STREET ADDRESS <b>1901 23rd ST.S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>TWIN"B" BABY GIRL</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>11 NOVEMBER 1961</b>	
9. AGE (In years last birthday) yrs. <b>8</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clayton E. Nicles</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Mae Rinehart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <b>FATHER: Clayton E. Nicles, 1901 23rd ST., SE, WASH, D.C.</b>		Address <b>8 hrs 20 min</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity (1 lb 5 oz)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>776X</b> (c) <b>776X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1050, 11 NOV. 1961</b> , to <b>1910, 11 NOV. 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11 November 1961</b> , and that death occurred at <b>1910</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>M.C. O'BANNON, LT MC USN</b>		22b. DATE SIGNED <b>11 November 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.C. O'BANNON, LT MC USN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-14-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Gaithersburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		25. REC'D BY REGISTRAR <b>NOV 14 '61</b>	
24. FUNERAL HOME <b>Rockville, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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Montgomery

Montgomery

Bethesda (Mental)

8 hrs Admin.

Washington, D.C.

U.S. NAVAL HOSPITAL

1901 21st St. S.W.

TWIN B. BAY GIRL

WICKES

NOVEMBER 11

61

CAUCASIAN

11 NOVEMBER 1901

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Montgomery, Maryland

Patricia Mae Rinehart

Clayton E. Nelson

FATHER: Clayton E. Nelson, 1901 23rd St., SE, WASH. D.C.

*Transcript (Vol. 200)*

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1050.11 NOV. 61

1050.11 NOV. 61

11 November 1901

11 November 1901

11 November 1901

M.C. O'BRIEN, JR. MD. NEW

11 November 1901

M.C. O'BRIEN, JR. MD. NEW

U.S. NAVAL HOSPITAL, BETHESDA, MD.

Calverton, Maryland

1900 Wheeler Hospital Home Records, Volume 1-100

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
15M 7/61

Item 20, File 301  
11-21-61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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12861

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>8 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SAN. &amp; Hosp.</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3726-17th St. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Ethel NMN O'CONNOR</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>Nov. 9 1961</u>		
<b>5. SEX</b> <u>FE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>9/12/82</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Ned Shaw</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary ANN</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		
<b>17. INFORMANT</b> <u>Pl's. chart</u>			<b>Address</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 830X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Multiple Fracture Pelvis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Bumper of daughter's car struck her hip; car in garage</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>4:00 PM</u> 1961 p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
<b>20f. (City or town)</b> <u>Washington DC.</u>		<b>20g. (County)</b> <u>DC.</u>		<b>20h. (State)</b> <u>DC.</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 2 1957</u> <b>to</b> <u>Nov 9 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Nov 9 1961</u> , <b>and that death occurred at</b> <u>4:40 PM</u> , <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>W.B. Wardrop MD</u>			<b>22b. DATE SIGNED</b> <u>Nov 9 1961</u>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W.B. WARDROP M.D.</u>			<b>22d. ADDRESS</b> <u>800 Pershing Drive Suite 400 N.W.</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11-13-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Lincolns Cemetery</u>	
<b>23d. LOCATION</b> (City, town, or county) <u>Prince Georges County Md.</u>		<b>23e. (State)</b> <u>Md.</u>		<b>23f. (County)</b> <u>Prince Georges County Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis A. Collins</u>			<b>24b. ADDRESS</b> <u>3821 14th St. N.E. WASHINGTON DC</u>		
<b>24c. REC'D BY REGISTRAR</b> <u>NOV 13 '61</u>			<b>24d. REGISTRAR'S SIGNATURE</b> <u>William S. Hume</u>		

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General Kennedy

W. B. KENNEDY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>3 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Hall</b>												2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring 40</b> d. STREET ADDRESS <b>2702 Harmon Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
3. NAME OF DECEASED (Type or print) <b>MARY</b>				First <b>AGNES</b>				Middle <b>PARDUHN</b>				Last <b>PARDUHN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>1961</b>																															
5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>November 23, 1877</b>				9. AGE (In years last birthday) <b>84</b> yrs.				IF UNDER 1 YEAR Months <b>4</b> Days <b>16</b>				IF UNDER 24 HRS. Hours <b>16</b> Min. <b>16</b>																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>								10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>								11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>								12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>																							
13. FATHER'S NAME <b>Michael Stupp</b>												14. MOTHER'S MAIDEN NAME <b>May Buckley</b>																																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>												16. SOCIAL SECURITY NO. <b>None</b>												17. INFORMANT <b>Mrs. Hyland A. Bizot</b> Address <b>2702 Harmon Street Silver Spring, Maryland</b>																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCT</b> <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY OCCLUSION</b> (c) <b>ARTERIO SCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe chronic debilitation</b>												INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>11</b> <b>years</b>																																			
20a. TIME OF INJURY Hour a.m. p.m. <b>19</b>												20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20d. (City or town) <b>Day</b>				20e. (County) <b>Nov</b>				20f. (State) <b>1961</b>																			
21. I certify that (I) (this hospital) attended the deceased from <b>day</b> <b>1958</b> to <b>Nov</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>Nov-12-1961</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.												22a. SIGNATURE <b>Richard P. Delaney</b> M.D. 22b. DATE SIGNED <b>NOV 28 '61</b>												22c. PHYSICIAN'S NAME (Type) <b>RICHARD P. DELANEY</b>												22d. ADDRESS <b>4323 Harvard St Silver Spring, Md</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>												23b. DATE THEREOF <b>11/28/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>				23d. LOCATION (City, town or county) <b>ARLINGTON, VIRGINIA</b>				23e. REC'D BY REGISTRAR <b>NOV 28 '61</b>				23f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>																			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b> ADDRESS <b>8434 GEORGIA AVENUE SILVER SPRING, MARYLAND</b>												24a. REC'D BY REGISTRAR <b>NOV 28 '61</b>												24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>																							

15858

15858



RECEIVED BY THE  
OFFICE OF THE  
ATTORNEY GENERAL  
MAY 10 1964  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12877

12863

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>69 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norfolk</b> d. STREET ADDRESS <b>879 Justis Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Gerald Wayne Patterson</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>18</b> Year <b>1961</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>13 March, 1957</b>		<b>9. AGE</b> (In years last birthday) <b>4</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None (child)</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>Joseph T. Patterson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Juan Cooke</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>				<b>17. INFORMANT</b> <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Edema</b> <b>204.3</b> DUE TO (b) <b>acute lymphocytic leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>11 months</b>																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)																					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> <b>Norfolk</b>				<b>(County)</b> <b>Norfolk</b>				<b>(State)</b> <b>Virginia</b>					
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10 Sept. 1961</b> to <b>18 Nov. 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>18 Nov. 1961</b> and that death occurred at <b>4:30 PM</b> from the causes and on the date stated above.																									
<b>22a. SIGNATURE</b> <b>Frederick H. Welland</b> M.D.										<b>22b. DATE SIGNED</b> <b>Nov. 18, 1961</b>				<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Frederick H. Welland</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial-transit 11-19-61</b>										<b>23b. DATE THEREOF</b> <b>11-19-61</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Forest Lawn Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) <b>Norfolk, Virginia.</b>				<b>(State)</b> <b>Virginia</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. PUMPHREY</b>										<b>ADDRESS</b> <b>Bethesda, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>NOV 22 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>C. L. S. Kline</b>							

(M)

(I)

ROBERT A. RIMNEY, Bethesda, Md.

Funeral services 11-19-51 Forest Lawn Cemetery, Norfolk, Virginia.

FREDERICK H. WELLS

The National Board of Health, Washington, D. C.

11 Nov.

51

10 Nov.

10 Nov.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12878

12864

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>                    </u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital,</u>		d. STREET ADDRESS <u>1001 Barrett Road</u>	
3. NAME OF DECEASED (Type or print) <u>Elva</u> <u>Florence</u> <u>Perrin</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>July 4, 1901</u>	9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months <u>          </u> Days <u>          </u> Hours <u>          </u> Min. <u>          </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>                    </u>	11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>
13. FATHER'S NAME <u>George Kemp</u>		14. MOTHER'S MAIDEN NAME <u>Rose Sanders</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Daughter: Roas Ann McCoy, Same as #2</u>		Address <u>                    </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO <u>                    </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>                    </u> (c) <u>                    </u>			INTERVAL BETWEEN ONSET AND DEATH <u>                    </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>          </u> p.m. <u>          </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>	20f. (City or town) (County) (State) <u>                    </u>
21. I certify that (a) (this hospital) attended the deceased from <u>Nov. 19, 1961</u> , to <u>Nov. 21, 1961</u> , that (b) (we) last saw the deceased alive on <u>Nov. 21, 1961</u> , and that death occurred at <u>6:45 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John W. Brackett</u> M.D.		22b. DATE SIGNED <u>November 21, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN W. BRACKETT, LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda Md.</u>	
23a. BURIAL (CREMATION) REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/21/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairfax Memorial Gardens</u>	23d. LOCATION (City, town or county) (State) <u>Fairfax Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Everly Funeral Home, W. Main St., Fairfax, Va.</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

13831

CENTROTECH OF DESIGN

13831

M

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>1 hr. 32 min.</b>		d. STREET ADDRESS <b>23 Galveston Place, SW</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Peterson</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> , Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 15, 1961</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>32</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) <b>Bethesda, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dale Carlton Peterson</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Jeanne Little</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT <b>FATHER: Dale C. Peterson, Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>prematurity</b> 774X DUE TO (b) <b>absent abdominal muscles, oligoamnios, multiple congenital anomalies</b> DUE TO (c) <b>absent abdominal muscles, oligoamnios, multiple congenital anomalies</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>November 15, 1961 to November 15, 1961</b> that (I) (we) last saw the deceased alive on <b>November 15, 1961</b> , and that death occurred <b>1:37 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>G. B. Avery</b>		22b. DATE SIGNED <b>November 15, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. B. AVERY LT MC USA</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/20/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>NOV 21 '61</b>	
ADDRESS <b>R. A. PUMPHREY Funeral Home, Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton L. Kraus</b>	

205119+XV2

1830

RECORDS OF DEATH

1831



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page]*

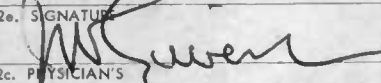
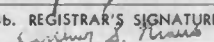
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12880											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>85 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Arizona</b> b. COUNTY <b>Tempe</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1707 Apache Boulevard</b> d. STREET ADDRESS <b>418-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>William Edward Pike</b>						4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 12, 1941</b>		9. AGE (In years last birthday) <b>20</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>8</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fish cutter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unemployed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Valence Pike</b>						14. MOTHER'S MAIDEN NAME <b>Evelyn Jones</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT <b>The Medical Record</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral anoxia</b> (c) <b>Post operative embolism, after correction of atrial septal defect.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Indeterminate</b> <b>72 hours</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 27, 1961</b> to <b>Nov. 20, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 20, 1961</b> , and that death occurred at <b>9:17 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE  M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>November 22, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Joseph W. Gilbert, M.D.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THROF <b>11/23/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>-</b>		23d. LOCATION (City, town or county) <b>TEMPE</b>		(State) <b>ARIZ</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co.</b>						ADDRESS <b>1400 Chapin St. N.W. Wash, D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>		25b. REGISTRAR'S SIGNATURE 	



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12881

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12867

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07 Gaithersburg</u>			
c. LENGTH OF STAY IN 1b <u>years</u>				d. STREET ADDRESS <u>13 De Selma Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13 De Selma Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Milton Pope</u>				4. DATE OF DEATH <u>Nov 6 1961</u>			
5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>5-22-79</u>			
9. AGE (in years last birthday) <u>82</u> yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>			
11. BIRTHPLACE (State or foreign country) <u>N.S.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>N.S.C.</u>			
13. FATHER'S NAME <u>Joseph Pope</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Flora Mobley - Gaithersburg md</u>			
17. INFORMANT <u>Flora Mobley - Gaithersburg md</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Interval between onset and death</u> (c) <u>sudden</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11-8-61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Joshua</u>				22d. LOCATION (City, town, or country) (State) <u>Gaithersburg md</u>			
23. FUNERAL DIRECTOR <u>Ernest C. Gaithersburg</u>				24a. REC'D BY REGISTRAR <u>NOV 8 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if necessary, by the medical examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1881

1881

(M)

(I)

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "Medical" and "Examination" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12882

12868

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>58</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6216 Walhounding Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>6216 Walhounding Road</b> d. STREET ADDRESS <b>6216 Walhounding Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Alden</b>		First <b>A.</b>		Middle <b>Potter</b>		Last <b>Potter</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>19 61</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/12/84</b>		9. AGE (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR Months <b>1</b> Days <b>16</b> Hours <b></b> Min. <b></b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gvt</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Alden H. Potter</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				17. INFORMANT <b>Lloyd A. Potter-Son, Bethesda, Maryland</b> Address							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lloyd A. Potter-Son, Bethesda, Maryland</b> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>7 years.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 min.</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19... to <b>Nov 28</b> , 1961, that (I) (we) last saw the deceased alive on <b>Nov 22, 1961</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>John W. Latimer</b>				M.D. <b>John W. Latimer, Jr</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>11/28/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>John W. Latimer, Jr</b>				22d. ADDRESS <b>1728 Mass. Avenue, N. W. Wash DC</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>11/29/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>			
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 1 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>			

12008

12008

Montgomery

Maryland

Montgomery

Bethesda

Bethesda

6316 Wainwright Road

6316 Wainwright Road

Nov. 20

Nov. 18

Nov. 18

White

White

1954

U. S. 247

Barred

John P. Porter

Thompson

Alfred A. Foster-Son, Bethesda, Md.

None

0

Nov. 18

Nov. 18

11/18/54

John W. Porter, Jr. 1728 Mass. Avenue, N. W. San DC

Robert A. Humphrey, Bethesda, Maryland  
Transmission 11/20/54  
John Hill Remedy, Bethesda, Maryland

## CERTIFICATE OF DEATH

Reg. Dist. No. 12869

12883

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>	
c. LENGTH OF STAY IN 1b <u>22 DAYS</u>		d. STREET ADDRESS <u>1500 MASS. AVE. NW</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bal Pre Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRIDA</u> Middle <u>RADEZY</u> Last <u>RADEZY</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 27, 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEW YORK</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>SIMON HAY</u>		14. MOTHER'S MAIDEN NAME <u>BETTY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>140</u>	
17. INFORMANT <u>ROSE KORDA</u> Address <u>1500 MASS. AVE. NW.</u>		18. DAUGHTER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>CANCER of the Colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>61</u> , to <u>11/24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11/24</u> , 19 <u>61</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max G. Sherer, M.D.</u>		ADDRESS (Street, city or town, state) <u>2025 Eye Street NW Wash DC 20004</u>	
PHYSICIAN'S NAME (Type) <u>MAX G. SHERER, M.D.</u>		DATE SIGNED <u>11/24/61</u>	
22a. BURIAL CREMATION, Removal (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV. 26, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW MT. CARMEL CEMETARY</u>	22d. LOCATION (City, town, or county) (State) <u>NY</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Langansky</u> ADDRESS <u>3501-14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BT 330M2U5-55A 1600-2000TRMS RMS 100A/100V

222

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12884

12870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> D.C. <u>47X-3</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md. 1 1/2 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3812 Livingston St. N.W. D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea Woodland Nursing Home</u>		d. STREET ADDRESS <u>3812 Livingston St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>LEILA</u> First <u>L.</u> Middle <u>RAND</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>-22</u> Year <u>-1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1866</u> 94 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HWF</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>John B. Rand</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Cheek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Philinda R. Anglemeyer</u>		Address <u>same as #3</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left ventricular cardiac failure</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>1 month</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 17</u> , 19 <u>61</u> , to <u>22 Nov</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>17 Nov</u> , 19 <u>61</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Seruch T. Kimble</u> M.D. <u>927 Pennington St., Silver Spring Md.</u>		DATE SIGNED <u>11-22-61</u>	
PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>11/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12284

(M)

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

NAME: [illegible]  
DATE: [illegible]  
CAUSE OF DEATH: [illegible]  
LOCATION: [illegible]

Additional fields include: SEX, AGE, OCCUPATION, and PLACE OF BIRTH. The form is divided into several horizontal sections for detailed medical and personal history.



1/6  
FOR STATE  
HEALTH DEPT.

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18, Film G 302 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12/5/61 12885 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12871

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>38 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		18	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>37 Philadelphia Ave</u>				d. STREET ADDRESS <u>37 Philadelphia</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Evelyn Alice Reaney</u>				4. DATE OF DEATH Month <u>nov</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-15</u>		9. AGE (in years last birthday) <u>46 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>L. Reaney</u>				14. MOTHER'S MAIDEN NAME <u>Alice Sharer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>U.S. Marine</u>		17. INFORMANT <u>Otto B Roepke - Item 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate Poisoning</u> <u>9778</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschek</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschek</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		11-21-61	
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>Nov. 21-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill Cemetery Prince Georges Co - Md.</u>	
23. FUNERAL DIRECTOR <u>Arthur Kellers</u>				ADDRESS <u>357 Carroll St. P.O. 712 Takoma Park - MD</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kings</u>			

1881



*[Faint, illegible handwriting at the bottom of the page, possibly a signature or address.]*

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12886

12872

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>1 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b> d. STREET ADDRESS <b>4415 Brockton Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Annie</b> Middle <b>Mae</b> Last <b>Rennoe</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>4,</b> Year <b>19 61</b>		<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>			
<b>13. FATHER'S NAME</b> <b>William Rennoe</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Minnie Cornell</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unascertainable</b>		<b>17. INFORMANT</b> <b>The Medical Records</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO <b>204.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Broncho pneumonia</b> DUE TO (c) <b>Acute Myelogenous leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 week</b> <b>3 months</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that</b> <b>XX</b> (this hospital) attended the deceased from <b>November 3, 1961</b> to <b>November 4, 1961</b> , that (X) (we) last saw the deceased alive on <b>November 4, 1961</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Edward S. Henderson</b>		<b>22b. DATE SIGNED</b> <b>November 6, 1961</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Edward S. Henderson</b>			
<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>		<b>22e. M.D.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Nov. 7 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Manassas</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Manassas</b>		<b>23e. (State)</b> <b>Va.</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Bochi sons</b>		<b>24a. ADDRESS</b> <b>Nycterville Ind</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 10 61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>		<b>25c. DATE</b>					

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

George Adams

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The Clinical Center, Bethesda, Md.

The Clinical Center, Bethesda, Md.

November 1, 1952

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November 1, 1952

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The Clinical Center, Bethesda, Md.

The Clinical Center, Bethesda, Md.

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The Clinical Center, Bethesda, Md.

The Clinical Center, Bethesda, Md.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12887

12873

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>153 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maine</b>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Portland</b>		d. STREET ADDRESS <b>270 Brackett Street</b>		578-3	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Patrick Francis Ridge</b>		4. DATE OF DEATH Month Day Year <b>November 19 19 61</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>July 14, 1909</b>		9. AGE (In years last birthday) <b>52 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yard conductor</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Ridge</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Ridge</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unavailable</b>		17. INFORMANT The Medical Record <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Less than one hour</b>  <b>YEARS</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Reticulum Cell Sarcoma</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that (this hospital) attended the deceased from <b>Jun. 19, 1961</b> to <b>Nov. 19, 1961</b> , that (we) last saw the deceased alive on <b>Nov. 19, 1961</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Michael Field</b>		M.D.		22b. DATE SIGNED <b>Nov. 20, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Michael Field, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 11/21/61</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>South Portland Calvary</b>		23d. LOCATION (City, town or county) <b>South Portland, Maine</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. F...</b>		25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15884

CERTIFICATE OF DEATH

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The official death certificate of the deceased is hereby certified to be correct and true.

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July 1, 1900

July 1, 1900

July 1, 1900

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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, any page may be retained for your files. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12874											
Item 2 Film G 301 11/21/61											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sanitarium &amp; Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Washington, D.C.</u> d. STREET ADDRESS <u>236 Jefferson St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>SARAH F Rigney</u>						4. DATE OF DEATH <u>11 16 1961</u>					
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-72</u>		9. AGE (in years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>						12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>					
13. FATHER'S NAME <u>John Freese</u>						14. MOTHER'S MAIDEN NAME <u>Mary Evans</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>Wash. San &amp; Hosp. Record.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE PULMONARY EMBOLISM</u> DUE TO (b) <u>BRONCHOPNEUMONIA</u> DUE TO (c) <u>FRACTURE LEFT HIP</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell to floor at Wheaton Nursing Home - fracture L.H. hip</u>					
20c. TIME OF INJURY Month, Day, Year <u>2:30 p.m. 10-29 1961</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home Wheaton Monty Md</u>						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>FRANK J. Bluschant</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Frank J. Bluschant</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED <u>11-17-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>Nov 20 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Wheaton Maryland</u>	
23. FUNERAL DIRECTOR <u>W. K. Huntemann &amp; Son</u>						24a. REC'D BY REGISTRAR <u>NOV 21 '61</u>					
ADDRESS <u>5732 Georgia Ave N. W. Washington D. C.</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12889

## CERTIFICATE OF DEATH

Reg. Dist. No. 12875

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>28</b> <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9105 Louis Ave.</b>		d. STREET ADDRESS <b>9105 Louis Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Lawrence</b> Last <b>Ritter</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/1/02</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>D.C. Transit Receiver of Revenue</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Barton Ritter</b>		14. MOTHER'S MAIDEN NAME <b>Adelaide Hamilton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>518-10-5631</b>	
17. INFORMANT <b>Agnes C. Ritter same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary heart dz., RBBB, angina, old infarction years</b> (c) <b>Carcinoma of bladder, recto-abdominal fistula 3 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old pulmonary tuberculosis, Old Pott's disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 1946</b> to <b>Nov 29, 1961</b> , that I last saw the deceased alive on <b>Nov 24, 1961</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sydney Leventhal</b> M.D.		ADDRESS (Street, city or town, state) <b>9110 Colverville Rd., Silver Spring, Md.</b>	
DATE SIGNED <b>11/29/61</b>			
PHYSICIAN'S NAME (Type) <b>Sydney Leventhal</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>11/30/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>2901 14th St. N.W.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		DATE <b>DEC 1 '61</b>	

1. Name of deceased  
 2. Sex  
 3. Age  
 4. Date of birth  
 5. Place of birth  
 6. Date of death  
 7. Place of death  
 8. Cause of death  
 9. Signature of physician  
 10. Signature of registrar  
 11. Date of registration

NAME OF DECEASED HARRY E. RICHARDS		SEX MALE	
AGE 35		DATE OF BIRTH 1910	
PLACE OF BIRTH NEW YORK		DATE OF DEATH 1945	
PLACE OF DEATH NEW YORK		CAUSE OF DEATH HEART DISEASE	
SIGNATURE OF PHYSICIAN J. H. RICHARDS		SIGNATURE OF REGISTRAR J. H. RICHARDS	
DATE OF REGISTRATION 1945		PLACE OF REGISTRATION NEW YORK	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12890

12876

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Montgomery</span> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Bethesda</span> c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">24 days</span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <span style="font-size: 1.2em;">Suburban Hospital</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Montgomery</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Chevy Chase</span> d. STREET ADDRESS <span style="font-size: 1.2em;">3502 Preston Court</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">Robert J. Rogers</span>		<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">Nov.</span> Day <span style="font-size: 1.2em;">12,</span> Year <span style="font-size: 1.2em;">19 61</span>		<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">June 4, 1905</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">56</span> yrs. IF UNDER 1 YEAR: Months <span style="font-size: 1.2em;">5</span> Days <span style="font-size: 1.2em;">1</span> IF UNDER 24 HRS.: Hours <span style="font-size: 1.2em;">1</span> Min. <span style="font-size: 1.2em;">1</span>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Sec. Pres.</span>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Hosp. Plan U.F.P.C.</span>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <span style="font-size: 1.2em;">Nebraska</span>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Patrick J. Rogers</span>						<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Mary Irwin</span>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <span style="font-size: 1.2em;">No</span>				<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">390-12-3791</span>				<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Bernice Rogers (wife)</span>				Address <span style="font-size: 1.2em;">same as above</span>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em; font-family: cursive;">Respiratory Failure</span> <span style="font-size: 1.5em;">163X</span> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <span style="font-size: 1.5em; font-family: cursive;">Coronary Thrombosis</span> (c) <span style="font-size: 1.5em; font-family: cursive;">The Lung</span> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <span style="font-size: 1.2em;">19</span> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)													
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">10/10</span> , 1961, to <span style="font-size: 1.2em;">11/12</span> , 1961, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10-11-61</span> , and that death occurred at <span style="font-size: 1.2em;">11 A.M.</span> , from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <span style="font-size: 1.5em; font-family: cursive;">Walter A. Kelly</span> M.D.						<b>22b. DATE</b> <span style="font-size: 1.2em;">11/ 12/61</span>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.5em; font-family: cursive;">W.H. Killax</span>						<b>22d. ADDRESS</b> <span style="font-size: 1.5em; font-family: cursive;">8218 Wisconsin Ave</span>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Bur-Transit 11/17/61</span>				<b>23b. DATE THEREOF</b> <span style="font-size: 1.2em;">11/17/61</span>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Holy Cross Cemetery</span>				<b>23d. LOCATION</b> (City, town or county) (State) <span style="font-size: 1.2em;">Milwaukee, Wisconsin</span>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">Robert A. Pumphrey, Bethesda, Maryland</span>						<b>25a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">NOV 14 '61</span>						<b>25b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em; font-family: cursive;">Arthur L. Hanna</span>	

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 9/60

MEDICAL CERTIFICATION

18&21 Film 1-15-62 305 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12891											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>montgomery</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK DOA</b>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington San + Hosp.</b>						d. STREET ADDRESS <b>1002 OSAGE St. 1</b>					
3. NAME OF DECEASED (Type or print) <b>Robert Richard Rudy</b>						4. DATE OF DEATH <b>11 20 1961</b>					
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-26-25</b>		9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ARMY (U.S.A.) (Capt.)</b>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Brookline Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>HENRY A.</b>						14. MOTHER'S MAIDEN NAME <b>VERA DOPKEEN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WWII</b>						16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>WIFE EVELYN RUDY</b> Address <b>1002 OSAGE AVE SILVER SPRING</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac heart failure</b> <b>433.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiac arrhythmia</b> (c) <b>Interstitial myocarditis</b> DUE TO (e), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Frank J. Broschak</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type) <b>FRANK J. Broschak</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) <b>11-20-61</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/21/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>W.W. Chambers Co. Washington DC</b>				22d. LOCATION (City, town, or country) (State) <b>Portland Maine</b>			
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Washington DC</b> ADDRESS						24a. REC'D BY REGISTRAR <b>NOV 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12892

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12878

1. PLACE OF DEATH a. COUNTY <b>Mont. Co.</b>	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Mont.</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN lb <b>1 hr 10 mins.</b>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Charles W. Saffell</b>	4. DATE OF DEATH <b>Nov. 11, 1961</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/3/81</b>
9. AGE (In years and birth day) yrs. <b>80</b>	10. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>La borer</b>	11b. KIND OF BUSINESS OR INDUSTRY <b>Sa nitary Comm.</b>
11c. BIRTHPLACE (State or foreign country) <b>Maryla nd</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Saffell</b>	14. MOTHER'S MAIDEN NAME <b>Betsy ?</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>
17. INFORMANT <b>Maria n Ca rlisle</b>	Address <b>/R.F.D. # 1 /Rockville</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive heart failure</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Lobar pneumonia (rt.)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>day</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> end in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>11-11-61</b>
ACTUAL SIGNATURE <b>Frank J. Broschert</b> EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>	Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-14-61</b>
22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	22d. LOCATION (City, town, or country) (State) <b>Gaithersburg Md.</b>
23. FUNERAL DIRECTOR <b>Ernest C. Gartner</b>	ADDRESS <b>Gaithersburg. Md.</b>
24a. REC'D BY REGISTRAR <b>NOV 14 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Gaithersburg</b>

VS. A15ME  
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DATE NOV 14 '61

Arthur L. House

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12879

1. PLACE OF DEATH e. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>45 BETHESDA</b> d. STREET ADDRESS <b>5919 ROLSTON ROAD</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>MICHAEL SAKSA</b>			4. DATE OF DEATH Month Day Year <b>Nov. 22 19 61</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/29/85</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
13. FATHER'S NAME <b>John Saksa</b>			14. MOTHER'S MAIDEN NAME <b>Mary Brutosky</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>Johanna Flaim (daughter) Same as above</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (e) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c) <b>GRADUAL</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 HRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 22 1961</b> to <b>Nov 22 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 22 1961</b> , and that death occurred at <b>11:23 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Leo Donovan</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/23/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leo Donovan</b>		22d. ADDRESS <b>5218 WISCONSIN AVE - BETHESDA MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 11-23-61</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 30 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>William J. Kneave</b>	

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Robert A. Murphy, Secretary, Pennsylvania State University, University Park, Pa.

Robert A. Murphy, Secretary, Pa.



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FOR STATE  
HEALTH DEPT.

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12894 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12880

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>40 Yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7206 Maple Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HAROLD</b> Middle <b>EugENE</b> Last <b>SAUNDERS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>12</b> , Year <b>19 61.</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29, 1890.</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Ret.) U. S. Navy</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>FRED H. SAUNDERS</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES YEARS</b>				16. SOCIAL SECURITY NO. <b>220-32-7005</b>			
17. INFORMANT <b>MRS. GRACE G. SAUNDERS, 7206 Maple Ave. Tak. Pk. Md.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart, Md.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Examination for - 131961</b>				22b. DATE THEREOF <b>Nov. 12, 1961.</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery Prince Georges Co. Maryland</b>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR <b>Arthur Walters</b>				24a. REC'D BY REGISTRAR <b>Nov 14 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>				24c. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>			

MEDICAL CERTIFICATION

15480



1900

1900

1900

1900

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be expedited within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12895						12881					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>					
c. LENGTH OF STAY IN 1b <b>7 Months</b>						d. STREET ADDRESS <b>11108 Dayton Street</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11108 Dayton Street</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First <b>SARAH</b> Middle <b>-</b> Last <b>SCHREIBER</b>						Month <b>November</b> Day <b>23</b> Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 14, 1889</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Spires</b>						14. MOTHER'S MAIDEN NAME <b>Ida -</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No -</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Nora Epstein 11108 Dayton St., Sil. Spg, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old Myocardial Infarction; Renal Insufficiency</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 HR.</b> <b>2 years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1</b> , 19 <b>61</b> , to <b>Nov. 23</b> , 19 <b>61</b> ; that (I) ( <del>we</del> ) last saw the deceased alive on <b>Nov. 22</b> , 19 <b>61</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Samuel Dessoff</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL DESSOFF</b>						22d. ADDRESS <b>1302-18th N.W. Wash D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 26, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		23d. LOCATION (City, town or county) <b>Brooklyn, New York</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b>						ADDRESS <b>4217 9th Street N.W., D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

12881

CERTIFICATE OF DEATH

12881



Marion

Silver Spring

1118 Dayton Street

BATON

Female

White

March 14, 1933

Homeville

Harry Jones

Home

1118 Dayton Street

U.S.A.

1118 Dayton Street

Silver Spring

Marion

Marion

BATON

November 23, 1933

March 14, 1933

Ida

1118 Dayton Street

Office: Federal Home 214 2nd Street N.W., D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

12896  
MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12882

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockington Md.</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		478-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rockington Garden Farm</u>		d. STREET ADDRESS <u>1304 Truchman NW</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Martin Seaman</u>		4. DATE OF DEATH Month Day Year <u>Nov 18 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25 1871</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>— — —</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Lewis Seaman</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Doty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>713-09-1912</u>	
17. INFORMANT <u>Wm. G. Gallen</u>		Address <u>1304 Truchman NW, Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chiloyenerative Myocarditis</u> DUE TO (c) <u>(Coronary Insuff + Pulmonic Heart Block)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11/16/61</u> <u>7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11/26/1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/26/1961</u> to <u>11/18/1961</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11/18/61</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard T. Moise</u>		22b. DATE SIGNED <u>11/18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard T. Moise</u>		22d. ADDRESS <u>7030 Laurel Ave Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>11-20-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, N.J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gardner F. Moore</u>		ADDRESS <u>1756 Pa. Ave. N.W.</u>	
25a. REC'D BY REGISTRAR <u>NOV 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

Wash, D.C.

15828

CERTIFICATE OF DEATH

15828





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

12897  
MONTGOMERY STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12883

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. LENGTH OF STAY IN 1b <u>3 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>			d. STREET ADDRESS <u>1 201 S. Washington St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>201 S. Washington St.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Robert Nicholas Shaver</u>					4. DATE OF DEATH <u>Nov 29 1961</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10-24-06</u>		9. AGE (In years last birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.E.</u>		11. BIRTHPLACE (State or foreign country) <u>N.E.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <u>Zebulon V. Shaver</u>					14. MOTHER'S MAIDEN NAME <u>Bertha Beck</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes WW1</u>					16. SOCIAL SECURITY NO. <u>238-05-7083</u>		17. INFORMANT <u>Bertha B. Shaver</u>		
					3525 Millville Road Baltimore, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 795.0 DUE TO <u>Aspiration of electric contents</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c) <u>Sudden</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>11-30-61</u>				
					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland					24a. REC'D BY REGISTRAR DATE <u>DEC 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Harts</u>		

12007 MEDICAL RECORDS OF THE

THE STATE  
HOSPITAL

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12007 MEDICAL RECORDS OF THE  
THE STATE HOSPITAL

12007 MEDICAL RECORDS OF THE  
THE STATE HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12898						12884							
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN lb <b>two days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>1523 LIVE OAK DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ROBERT ARTHUR SHAW</b>						4. DATE OF DEATH <b>Nov. 23 1961</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 2, 1913</b>		9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Harry Shaw</b>						14. MOTHER'S MAIDEN NAME <b>Katherine P. Broffitt</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>577-03-8227</b>						17. INFORMANT <b>Mrs. Helen K. Shaw</b> Address <b>1523 Live Oak Drive Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>												INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Silver Spring</b>		20g. (County) <b>Montgomery</b>		20h. (State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 23 1961</b> to <b>Nov 23 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 23 1961</b> , and that death occurred at <b>Nov 23 1961</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Dr. John S. Rogers</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov 24, 1961</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. John S. Rogers</b>						22d. ADDRESS <b>1919 Seminary Road, Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/27/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Montgomery County, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b>						25a. REC'D BY REGISTRAR <b>Nov 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

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1911 Silver Spring

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1911 Silver Spring

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12885

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cabin John</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7905 Woodrow Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH M.</b> Middle <b>SHEPHERD</b> Last <b>SHEPHERD</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 10, 1872</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Madison Co., Ind.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Shepherd</b>		14. MOTHER'S MAIDEN NAME <b>Flora Heidy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Son.</b> <b>George J. Shepherd</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>GENERAL ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>10 YEARS</b> <b>10 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>OCT. 15, 1954</b> , to <b>NOV. 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>NOV. 24, 1961</b> , and that death occurred at <b>9:50 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert G. Angle</b>		22b. DATE SIGNED <b>NOV. 25, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT G. ANGLE</b>		22d. ADDRESS <b>5009 Del Ray Ave., Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 11-26-61</b>		23b. DATE THEREOF <b>11-26-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gravell Lawn</b>		23d. LOCATION (City, town, or county) (State) <b>Fortville, Indiana</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>NOV 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William E. Pinner</b>	

1883

CERTIFICATE OF DEATH

1883

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12900  
MONTGOMERY  
12386  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>14 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>59 Bethesda</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>8000 Whittier Blvd.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>J.</b> Last <b>Shipley</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/19/02</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>13</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS. Months <b>59</b> Days <b>13</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Serv-Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Emerson &amp; Orme</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph J. Shipley</b>		14. MOTHER'S MAIDEN NAME <b>Grace Hipsley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>578-03-4062</b>	
17. INFORMANT <b>Milford A. Shipley (brother)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.1</b> DUE TO (c) <b>Cervical Neuritis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cervical Neuritis.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 20</b> <b>1961</b> to <b>Nov. 13</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert N. Goale</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert N. Goale</b>		22d. ADDRESS <b>4429 Bradley Lane, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-16-61</b>		23b. DATE THEREOF <b>11-16-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Wash DC</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Sutermeister &amp; Son</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 15 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		25c. REGISTRAR'S SIGNATURE	

STATE OF NEW YORK  
COUNTY OF NEW YORK

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12387

1. PLACE OF DEATH COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON, MD.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 29</b>			
c. LENGTH OF STAY IN 1b <b>1 YEAR</b>				d. STREET ADDRESS <b>1007 North Mansion Drive</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WHEATON Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elizabeth Felicite Sholz</b>				4. DATE OF DEATH <b>11 10 19 61</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-8-1871</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BROOKLYN, N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>CHARLES GIESE</b>				14. MOTHER'S MAIDEN NAME <b>ANNA MARIE Schroth</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs. Bernard T. Haumett</b>				Address <b>1007 N. Mansion Drive Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b>							
420.0 DUE TO (b) <b>arterio-sclerotic heart disease</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>generalized arterio-sclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cerebral vascular accident</b>							
19. INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State)	
21. I certify that (1) (the hospital) attended the deceased from <b>1953</b> to <b>1961</b> , that (1) (we) last saw the deceased alive on <b>10-10-1961</b> , and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>H. F. Kreuzburg</b>				22d. ADDRESS <b>7852 16th Ave Wash DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<b>TRANSIT-BURIAL</b>		<b>11/11/61</b>		<b>CRYSTAL LAKE CEMETERY</b>		<b>GARDNER, MASS.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				ADDRESS <b>8434 GEORGIA AVENUE</b>			
<b>WARNER E. PUMPHREY, INC.</b>				<b>SILVER SPRING, MD.</b>			
25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			
DATE <b>NOV 14 '61</b>							

TO HOST: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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## 10/11/16 DATE TIME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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12902  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12888

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>10 1/2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3223 Leland St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>G</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>19 61</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/14/1877</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Bagg</b>		14. MOTHER'S MAIDEN NAME <b>Anna Goodwin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>F. C. Smith</b>		Address <b>3223 Leland St. Ch.Ch. Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intractable heart failure</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized carcinomatosis</b> DUE TO (c) <b>Adenocarcinoma of the colon</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 hours</b> <b>11 mos.</b> <b>11 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic cardiovascular disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1951</b> , to <b>Nov. 5, 19 61</b> that (I) (we) last saw the deceased alive on <b>Nov. 2, 19 61</b> , and that death occurred at <b>7:40 a.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Andrew A. Marchetti</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Andrew A. Marchetti, M.D.</b>		22d. ADDRESS <b>Gerogetown University Hosp., Wash. 7, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/8/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gaudier's Son</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 9 '61</b>	
ADDRESS <b>1756 Pa. Ave. NW, Wash. DC</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

12882

CERTIFICATE OF DEATH

12882

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12889

12903

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>46 BETHESDA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>5501 N. Field Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>George Carlton Smith Jr.</b>		4. DATE OF DEATH <b>11 23 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 30, 1913</b>
9. AGE (In years last birthday) <b>47</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deputy Marshall</b>	
11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George C. Smith</b>		14. MOTHER'S, MAIDEN NAME <b>Helen H. Aerson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Josephine A. Smith</b>		Address <b>5501 N. Field Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melastatic Carcinomatosis</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cholangiocarcinoma of</b> (c) <b>Rectum</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 1959</b> to <b>11/23/1961</b> , that I last saw the deceased alive on <b>11/4/1961</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. T. Jones</b>		ADDRESS (Street, city or town, state) <b>8106 Maple Ridge Rd Bethesda, Md</b>	
PHYSICIAN'S NAME (Type) <b>W. T. Jones</b>		DATE SIGNED <b>11/23/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-27-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deaf Lawrence Hume</b>		ADDRESS <b>4812 Ga Ave NW</b>	
24a. REC'D BY REGISTRAR <b>NOV 29 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	



TO HO, 1, 4, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12904

## CERTIFICATE OF DEATH

12890

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		d. STREET ADDRESS <b>3278 Worthington St., N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Maude S. Smith</b>		4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1886</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Hopkins</b>		14. MOTHER'S MAIDEN NAME <b>Florence Brush</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>O. Frank Loekle (son-in-law)</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>153.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Confluent Bronchopneumonia 2-100</b> <b>Peritonitis, intestinal obstruction</b> <b>Carcinoma, ileo-cecal valve</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>e.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-34</b> , 19 <b>61</b> , to <b>11-30</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11-30</b> , 19 <b>61</b> , and that death occurred at <b>11:45</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter Atkinson</b>		22b. DATE SIGNED <b>11/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter Atkinson</b>		22d. ADDRESS <b>1835 Eye St. N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE THEREOF <b>12/1/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairmount Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Newark, N.J.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>DEC 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		DATE	

M

1

Montgomery

Bethesda

Calverton

Manassas

Pentagon

Washington

Valley Forge

No

30 days

2700 Northampton St., N.W.

Smith

S.

Aug 15, 1888

New Jersey

Flourville Road

O. Frank Loomis (born in Iowa) came to above

Confident Travel of Americans 1-100  
Pardon N. 1, interest of children  
Governance, also - great value

Valley Forge

1888

Revised

2nd Edition

The S. S. Lines Co. Washington, D. C.

1  
To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12905  
Item 2 Film 0299  
11/8/61  
12891

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>2 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		d. STREET ADDRESS <b>4514 Connecticut Ave. Kensington Gardens Sanitarium</b>	
3. NAME OF DECEASED (Type or print) <b>STELLA</b> First Middle Last <b>SNYDER</b>		4. DATE OF DEATH <b>November 2 1961</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1870</b>
9. AGE (In years lost birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Reinsmith</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Medical Record</b> Address <b>Kensington Gardens San.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure (arteriosclerotic)</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Serious long 90 -</b> (b) <b>Serious long 90 -</b> (c) <b>Serious long 90 -</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Generalized</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week yrs yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/11/61</b> 19 <b>11/2/61</b> 19 <b>11/2/61</b> , that (I) (we) last saw the deceased alive on <b>11/1/61</b> 19 <b>11/2/61</b> , and that death occurred at <b>7:40 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>SAM ALLEN</b>		22b. DATE SIGNED <b>11/2/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sam Allen</b>		22d. ADDRESS <b>Kensington, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/7/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Guolieri &amp; Son, Inc. 1756-1a Ave NW</b>		25a. REC'D BY REGISTRAR <b>NOV 6 '61</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

(M)

(A)

1921

1921

CENTRAL OF DEATH

CO. GREEN CAMP 10

1921



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If not, it may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12906

## CERTIFICATE OF DEATH

12892

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>34 Silver Springs</b> d. STREET ADDRESS <b>1 SHERATON 2717 Sheridan St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Anna</b> First Middle Last 4. DATE OF DEATH <b>Sprague 11 30 19 61</b> Month Day Year			5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>4/4/21</b> 9. AGE (In years last birthday) <b>40 yrs.</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Emanuel Bpjokles</b> 14. MOTHER'S MAIDEN NAME <b>Florence Papadakis</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>UNK.</b> 17. INFORMANT <b>Mrs. Despina Seal, sister - 100 N. Oakland St.</b> Address <b>Arlington, Va.</b>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adrenal hemorrhage, bilateral</b> 274X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>1-Pelvic abscess 2-Rheumatic valvular heart disease with subacute bacterial endocarditis</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <b>11-25</b> to <b>11-30</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11-30</b> , 19 <b>61</b> , and that death occurred at <b>8:35 P.</b> M, from the causes and on the date stated above.		
22a. SIGNATURE <b>W F Marcus</b> 22c. PHYSICIAN'S NAME (Type) <b>W F MARCUS</b> 22d. ADDRESS <b>10620 Georgia Ave</b>			22b. DATE SIGNED <b>12/1/61</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Dec. 4, 1961</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b> 23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>			25a. REC'D BY REGISTRAR <b>DEC 4 '61</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		
24 FUNERAL DIRECTOR'S SIGNATURE <b>W W Taitanell</b> ADDRESS <b>3603 14th St NW DC 10</b>					



12302

12302



Adrenal hemorrhage, bilateral

1- Pelvic abscess 2- Rheumatic valvular heart disease with sub-  
cutaneous bacterial emboli

11-25 11-25 11-25

11-25

10220 George

W. F. Marcus  
W. F. Marcus

Cedar Manor, Md.

Dec. 4, 1951 Fort Lincoln

Serial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12907

## CERTIFICATE OF DEATH

12893

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
c. LENGTH OF STAY IN lb <u>43 days</u>		d. STREET ADDRESS <u>3201 Wisconsin Ave. NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lawrence (n) Stansell</u>		4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1901</u>
9. AGE (In years last birthday) yrs. <u>60</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse P. Stansell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Skinner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI WWII</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>WIFE: Juanita M. Stansell, Same as #2</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory cessation</u> DUE TO (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Pulmonary and hepatic metastases of Ca pancreas</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that <u>M</u> (this hospital) attended the deceased from <u>October 2, 1961</u> to <u>November 13, 1961</u> that <u>M</u> (we) last saw the deceased alive on <u>November 13, 1961</u> , and that death occurred at <u>9:13 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph H. Eusterman</u> M.D.		22b. DATE SIGNED <u>November 13, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH H. EUSTERMAN LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 16, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. PUMPHREY</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 16 '61</u>	
ADDRESS <u>R. A. PUMPHREY Funeral Home, Bethesda, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

15993

CERTIFICATE OF DEATH

15993

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12894

12908

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nyattsville</u> d. STREET ADDRESS <u>2805 Nicholson St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Florine C. Steele</u>		<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>21</u> Year <u>1961</u>		<b>5. SEX</b> <u>Female</u>			
<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 2, 1890</u>			
<b>9. AGE</b> (In years last birthday) <u>71</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>United States of America</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>United States of America</u>		<b>13. FATHER'S NAME</b> <u>Benjamin Cullison</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Evelina Gibson</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>			
<b>17. INFORMANT</b> <u>Jean Talies - Washington San. &amp; Hosp.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <u>153.8 Carcinoma of colon - metastatic to lungs and liver</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Essential hypertension; arteriosclerosis; chronic hyperlipidemia; chronic peripheral vascular disease</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 1955</u> <b>to</b> <u>11-21-61</u> <b>and that (I) (we) last saw the deceased alive on</b> <u>11-21-61</u> <b>and that death occurred at</b> <u>7:40</u> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Jason Geiger</u>		<b>22b. DATE SIGNED</b> <u>11-21-61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Jason Geiger, M.D.</u>			
<b>22d. ADDRESS</b> <u>1112 Spring St. S.S. Md.</u>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22f. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11-24-1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Baltimore, Maryland</u>		<b>23e. REGISTRAR'S SIGNATURE</b> <u>Arthur S. K...</u>		<b>23f. DATE</b> <u>NOV 24 '61</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Co., Riverdale, Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE BOARD OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12909 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12895

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>x Silver Spring</i>			
c. LENGTH OF STAY IN 1b <i>11 days</i>				d. STREET ADDRESS <i>10312 Lanston Lane</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Viola</i> Middle <i>Jane</i> Last <i>Stevenson</i>		4. DATE OF DEATH Month <i>11</i> Day <i>11</i> Year <i>1961</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-11-70</i>	9. AGE (in years last birthday) <i>91</i> yrs.	IF UNDER 1 YEAR Months <i>11</i> Days <i>11</i>	IF UNDER 24 HRS. Hours <i>11</i> Min. <i>11</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>James M. Lane</i>				14. MOTHER'S MAIDEN NAME <i>Nancy Dooley</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Washington Sanitarium &amp; Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION</i> DUE TO <i>1904.0</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>CORONARY OCCLUSION</i> (c) <i>FRACTURE LEFT HIP</i>							INTERVAL BETWEEN ONSET AND DEATH <i>3 DAYS</i> <i>3 DAYS</i> <i>12 DAYS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>BRONCHOPNEUMONIA, ACUTE</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Reported fell at home fracturing left hip</i>					
20c. TIME OF INJURY Month, Day, Year <i>9 10-31 1961</i> Hour a.m. <i>9</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>		20f. (City or town) <i>Silver Spring monty MD</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Blomhart</i>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>11-11-61</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Blomhart</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, or other disposition <i>Interment</i>		22b. DATE THEREOF <i>11/12/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lebanon</i>		22d. LOCATION (City, town, or country) (State) <i>Indiana</i>	
23. FUNERAL DIRECTOR <i>F Gasch's Sons</i> ADDRESS <i>Hyattsville Md.</i>				24a. REC'D BY REGISTRAR <i>NOV 14 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Krause</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12910

CERTIFICATE OF DEATH

12896

Items 3 & 13 Film G300 ink 11/9/61

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Virginia</b> b. COUNTY <b>Virginia</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>		
c. LENGTH OF STAY IN lb <b>25 days</b>			d. STREET ADDRESS <b>1313 Stoneybrae Drive</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>John William Stockbrand</b>			4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1961</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>Caucasian</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>			8. DATE OF BIRTH <b>July 27, 1892</b>		
9. AGE (In years last birthday) <b>69 yrs.</b>			10. IF UNDER 1 YEAR Months <b>69</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>School Teacher</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Kansas</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William H. Stockbrand</b>			14. MOTHER'S MAIDEN NAME <b>Augusta Bayer</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>515-09-1296</b>		
17. INFORMANT <b>SON: Archie P. Stockbrand, same as #2</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Carcinoma of the Prostate with</b> (c) <b>multiple metastases</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 10, 1961</b> to <b>November 3, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 3, 1961</b> , and that death occurred at <b>3:04 AM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>H. S. Irons</b>			22b. DATE SIGNED <b>November 3, 1961</b>		
22c. PHYSICIAN'S NAME (Type) <b>H. S. IRONS LT MC USN</b>			22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11-4-61</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Municipal Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Yates Center, Kansas</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>			25a. REC'D BY REGISTRAR <b>NOV 6 '61</b>		
ADDRESS <b>Bethesda, Maryland</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12911

## CERTIFICATE OF DEATH

12897

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St Marys</u> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>	
c. LENGTH OF STAY IN 1b <u>1 hr. 50 mins.</u>		d. STREET ADDRESS <u>56 W. Rennell</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Kevin</u> Middle <u>Joe</u> Last <u>Styer</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 16, 1961</u>
9. AGE (in years last birthday) yrs. <u>0</u> Months <u>1</u> Days <u>1</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -	
10a. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Walter McRae Styer</u>	
14. MOTHER'S MAIDEN NAME <u>Jacqueline Jo Fowler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. -		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> <u>770.0</u> DUE TO <u>Paternal Transfusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Paternal Transfusion</u> (c) <u>Paternal Transfusion</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>12:50PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>November 17, 1961</u> to <u>November 17, 1961</u> , that (f) (we) last saw the deceased alive on <u>November 17, 1961</u> , and that death occurred at <u>12:50PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard H. Feldman</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD H. FELDMAN LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-24-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		25a. REC'D BY REGISTRAR <u>NOV 24 '61</u>	
ADDRESS <u>W.W. CHAMBERS Funeral Home, Washington, D. C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12912

## CERTIFICATE OF DEATH

12398

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WHEATON NURSING HOME</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2127 - EAST 2nd ST., 43X-3</u> d. STREET ADDRESS <u>Long Beach, California</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>(SWEET) Agnes Ellen SWEET</u> First Middle Last f. SEX <u>F</u> g. COLOR OR RACE <u>W</u> h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		i. DATE OF DEATH <u>Nov 5 1961</u> Month Day Year j. AGE (In years last birthday) <u>96</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>		k. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> l. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> m. BIRTHPLACE (County & State, or foreign country) <u>Unity, Maine</u> n. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>LUDLEY PERLEY CLARK</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lucy Ellen WARE</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Mrs. Nancy Canning 700 Sligo Avenue Silver Spring, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>331X</u> DUE TO <u>331X</u> DUE TO <u>331X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 DAYS</u> <u>25 YEARS</u> <u>20 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov 2, 1960</u> <b>to</b> <u>Nov 5, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>19</u> <b>and that death occurred at</b> <u>M</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Belden R. Reap</u> M.D. <b>22b. PHYSICIAN'S NAME (Type)</b> <u>BELDEN R. REAP, M.D.</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>11502 Grandview Ave., Wheaton, Md.</u>		<b>22b. DATE SIGNED</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial-Transit</u>		<b>23b. DATE THEREOF</b> <u>11/10/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Forest Lawn Memorial Park</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A. Ziska</u>		<b>ADDRESS</b> <u>8434 Georgia Avenue</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE NOV 7 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Kraus</u>		<b>25c. REGISTRAR'S SIGNATURE</b> <u>William S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 12899

12913

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>1 week</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belmont Nursing Home</u>			e. STREET ADDRESS <u>17814 Yarker Ave</u>		
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>R.</u> Last <u>Tennyson</u>			4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1897</u>		9. AGE (In years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>Dist. of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William F. Howard</u>			14. MOTHER'S MAIDEN NAME <u>De Ment</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	INFORMANT <u>Mrs. Mac Donald</u>		Address <u>Belmont Nur. Home</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebra thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>several yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>11/11/61</u> 19 _____ to <u>11/19/61</u> 19 _____, that I last saw the deceased alive on <u>11/11/61</u> 19 _____, and that death occurred at <u>2:30 P.</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Donald Nelson</u>		ADDRESS (Street, city or town, state) <u>10620 Georgia Ave S/Spr, Md 11/19/61</u>			
PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>		DATE SIGNED _____			
22a. BURIAL, CREMATION, <del>XXXXXX</del> <u>Burial</u>		22b. DATE THEREOF <u>Nov. 22, 1961</u>	22c. NAME OF CEMETERY OR <del>XXXXXX</del> <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>		ADDRESS <u>8655 Georgia Ave., S.S., Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 21 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12300											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>19 days</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 51 Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>7107 Fulton Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Grace Winter Thompson</u>				4. DATE OF DEATH <u>Nov 14 1961</u>				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 2, 1899</u>		9. AGE (In years last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (State or foreign country) <u>New Berlin Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William P. Winter</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth James</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Sister Ruth Cameron</u>				Address <u>State College Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> 9180 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Toxic Myocarditis</u> (c) <u>3rd Degree Burns - 30-40% Body Surface</u> DUE TO (e), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>3 DAYS</u> <u>26 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>2</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Woman caught fire from gas stove at home</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>2:30</u> p.m. <u>10-24</u> 1961				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> el work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Cherry Chase montg. md</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>11-15-61</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>11/16/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 17 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					



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1931

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Robert A. Farnsworth, Bethesda, Maryland  
L. J. Farnsworth, Cedar Hill, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12913

12901

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>105 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Washington</b> b. COUNTY <b>Yakima</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>106 North Fifth Avenue</b> d. STREET ADDRESS <b>84X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Juanita Beth Thompson</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>November 27, 1961</b>		
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>March 9, 1914</b>		<b>9. AGE</b> (In years last birthday) <b>47 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Teacher</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Education</b>		
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Montana</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Elias Ruegamer</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Annetta Vaupel</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <b>516-26-6531</b>		
<b>17. INFORMANT</b> (Address) <b>The Medical Record</b>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adrenocortical Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>1950</b> (c) <b>1950</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>August 11, 1961</b>	
<b>20f. (City or town)</b> <b>November 27, 1961</b>		<b>20g. (County)</b> <b>12:05AM</b>		<b>20h. (State)</b> <b>November 27, 1961</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital)</b> attended the deceased from <b>August 11, 1961</b> to <b>November 27, 1961</b> that <b>(he)</b> <b>(we)</b> last saw the deceased alive on <b>November 27, 1961</b> and that death occurred <b>November 27, 1961</b> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>M. A. Kirshner</b>			<b>22b. DATE SIGNED</b> <b>November 27, 1961</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Marvin A. Kirshner</b>			<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>		
<b>23a. BURIAL - CREMATION REMOVAL</b> (Specify) <b>removal</b>		<b>23b. DATE THEREOF</b> <b>11/28/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Billings, Montana</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H.Hines Co., 2901 14th St. N.W.</b>		<b>ADDRESS</b> <b>Wash. D.C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 29 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>					

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100 days

January

100 North Fifth Avenue

The Clinical Center, Bethesda 14, Md.

November 27, 1951

Thompson

Beck

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March 2, 1951

Female

U.S.A.

Montana

Education

Teacher

After treatment

Amelia Vogel

The Medical Record

51-26-231 The Clinical Center, Bethesda 14, Maryland

ret. condition: cured

x

August 10, 1951

November 27, 1951

November 27, 1951

The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

W. H. Brown

Willard, Montana

November 11, 1951

The S. H. Hines Co., 2001 17th St. N.W., Wash. D.C.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12916

## CERTIFICATE OF DEATH

12902

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11901 Georgia Avenue</b> <b>Wheaton Nursing Home</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> <span style="float: right;">b. COUNTY <b>--</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1665 Harvard St., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>Charles</b>		<b>4. DATE OF DEATH</b> Month <b>Nov</b> Day <b>16</b> Year <b>1961</b>		<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8/8/1869</b>		<b>9. AGE</b> (In years last birthday) <b>92</b> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																		
Months	Days																		
Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired --</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Chiropractor</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>											
<b>13. FATHER'S NAME</b> <b>Thomas Trazzare</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Sears</b>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>579-38-5425</b>				<b>17. INFORMANT</b> Address <b>11906 Colin Road</b> <b>Mrs. Ruth Wright-Silver Spring, Md.</b>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coagestive Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)																			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>Sept 15, 1959</b> to <b>Nov 16, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Nov 15, 1961</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <b>Neil P. Campbell</b> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>3060-16th St.</b>													
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Neil P. Campbell</b>						<b>22b. DATE SIGNED</b> <b>11/16/61</b>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>11/18/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Congressional Cemetery Washington, D.C.</b>				<b>23d. LOCATION</b> (City, town or county) (State)									
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H. Hines Co. - 2901 14th St., N.W.</b> <b>Washington 9, D.C.</b>																			
<b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 17 '61</b>						<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

12002

12002

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12917

12903

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <span style="float: right;">c. LENGTH OF STAY IN 1b <u>6 days</u></span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Alabama</u> <span style="float: right;">b. COUNTY <u>                    </u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntsville,</u> <span style="float: right;"><u>40 X 3</u></span> d. STREET ADDRESS <u>2315 Meridan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Reba</u>		First <u>Reba</u> Middle <u>-</u> Last <u>Treece</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>22</u> Year <u>19 61</u>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
<b>8. DATE OF BIRTH</b> <u>24 June 1928</u>		<b>9. AGE</b> (In years last birthday) <u>33</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None (Housewife)</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Alabama</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>John Doss</u>							
<b>14. MOTHER'S MAIDEN NAME</b> <u>Ginney Yancy</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>							
<b>17. INFORMANT</b> <u>The Medical Record,</u> <u>The Clinical Center, Bethesda 14, Maryland</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> (b) <u>Disseminated Blastomycosis</u> (c) <u>                    </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>                    </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>                    </u>							
<b>20f. (City or town)</b> <u>                    </u>		<b>20g. (County)</b> <u>                    </u>		<b>20h. (State)</b> <u>                    </u>							
<b>21. I certify that</b> (X (this hospital) attended the deceased from <u>Nov. 16</u> <u>1961</u> to <u>Nov. 22</u> <u>1961</u> , that (X) (we) last saw the deceased alive on <u>Nov. 22</u> <u>1961</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>John Bennett</u>		<b>22b. DATE SIGNED</b> <u>11-22-61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>John Bennett M.D.</u>							
<b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-transit 11-23-61</u>									
<b>23b. DATE THEREOF</b> <u>11-23-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greens Chapel Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Scottsboro, Alabama</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 30 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>                    </u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



Page 21

Enclosure

1. Clinic, Bethel, Alaska

2. Home

3. Clinic, Bethel, Alaska

4. Home

5. Clinic, Bethel, Alaska

6. Home

7. Clinic, Bethel, Alaska

8. The Clinical Center, Bethel, Alaska

9. Home

10. Clinic, Bethel, Alaska

11. Home

12. Clinic, Bethel, Alaska

13. The Clinical Center, Bethel, Alaska

14. Home

15. Clinic, Bethel, Alaska

16. Home

17. Clinic, Bethel, Alaska



TO HO<sup>1</sup> OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12918

12905

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>22 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. NAVAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>VA.</b> b. COUNTY <b>STAFFORD (Rural)</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ST #1 BOX 285</b> d. STREET ADDRESS <b>83 X 3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOUISE HELEN VEAZEY</b>		4. DATE OF DEATH <b>November 15 19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 18, 1928 32s.</b>	
9. AGE (In years last birthday) <b>32s.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LIONEL TRAHAN</b>		14. MOTHER'S MAIDEN NAME <b>EDDAY LANGLINIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>(If yes give word or dates of service)</b>	
17. INFORMANT <b>HUSBAND: Lynn J. Veazey, Same as #2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Advanced pulmonary metastases</b> DUE TO <b>carcinoma of the breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of the breast</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>October 24 1961</b> to <b>November 15 61</b> at <b>we</b> last saw the deceased alive on <b>November 15 19 61</b> and that death occurred at <b>8:15 pm</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>B.M. SHEPARD LT MC USN</b>		22b. DATE <b>16 November 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>B.M. SHEPARD LT MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-17-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ABBEVILLE</b>		23d. LOCATION (City, town or county) (State) <b>ABBEVILLE, LOUISIANA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Humphrey</b>		25a. REC'D BY REGISTRAR <b>NOV 21 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>		25c. REGISTRAR'S SIGNATURE	

12305

CERTIFICATE OF DEATH

12305

VA.

MONTGOMERY

STAFFORD (RURAL)

Patience (Rural) 25 days

RI 41 BOX 285

U. S. NAVAL HOSPITAL

November 15 61

LOUISE HELEN VENEY

Female Caucasian November 18, 1928 32

USA

EDDY LANGILHAIS

LEONEL TRAHAN

October 21 of November 25 61

8:15 pm November 15 61

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

12919  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12906

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>3 hrs.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanit Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>1312 Dennis Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>First Middle Last</i> <i>Mattie Elzora Wagner</i>		4. DATE OF DEATH <i>Month Day Year</i> <i>11 - 26 - 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-31-88</i>
9. AGE (In years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Va</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.G.</i>		13. FATHER'S NAME <i>Adie Wagner</i>	
14. MOTHER'S MAIDEN NAME <i>Gillie Barber</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Washington Sanitarium &amp; Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Previous CVA in July 1961</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
24. EXAMINER'S NAME (Type) <i>FRANK J. BROSCHELT</i>		25. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
26. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		27. DATE SIGNED <i>11-26-61</i>	
28. Address (Street, city, town, or county)		29. 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	
30. 22b. DATE THEREOF <i>11-29-61</i>		31. 22c. NAME OF CEMETERY OR CREMATORY <i>River View Cemetery</i>	
32. 22d. LOCATION (City, town, or country) (State) <i>Waynesboro, Va</i>		33. 23. FUNERAL DIRECTOR <i>Eves Funeral Home - Arlington, Va</i>	
34. 24a. REC'D BY REGISTRAR <i>NOV 28 '61</i>		35. 24b. REGISTRAR'S SIGNATURE <i>Clifford S. Plante</i>	

MEDICAL CERTIFICATION

1990



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12907

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>10425 Darnstown Rd 1</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mercy B. Ward</i>		4. DATE OF DEATH Month Day Year <i>November 5 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-8-92</i>
9. AGE (In years lost birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Rockville - MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Ignatius Beall WARD</i>		14. MOTHER'S MAIDEN NAME <i>ELIZ. FRANCES GARRETT</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT (Niece) <i>ELIZ. B. BANKS</i>		Address <i>10513 DARNSTOWN RD ROCKVILLE</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic cardiovascular disease</i> years DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>essential hypertension</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1955</i> to <i>Nov. 5 1961</i> , that (I) (we) last saw the deceased alive on <i>Nov 4 1961</i> , and that death occurred at <i>3:45</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Stephen C. Cromwell</i> M.D.		22b. DATE SIGNED <i>11-5-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Stephen C. Cromwell</i>		22d. ADDRESS <i>615 W. Montgomery Ave Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/8/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR <i>NOV 8 '61</i>	
ADDRESS <i>Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

1895

THE BUREAU OF THE CENSUS

1895



*[Faint, mostly illegible text from the reverse side of the page, appearing as bleed-through. Some words like 'Bureau', 'Census', and 'Manual' are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12921

12908

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>DIST. OF C.D.L.</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3464 McComb St N.W.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary Thornton Watson</u>		<b>4. DATE OF DEATH</b> <u>November 14 1961</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9-5-76</u>	<b>9. AGE</b> (In years last birthday) <u>85</u> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>— — —</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>CALIFORNIA</u>
<b>13. FATHER'S NAME</b> <u>John C. Watson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Thornton</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
<b>17. INFORMANT</b> <u>Sister. SARAH Watson</u>		<b>18. ADDRESS</b> <u>Same as above</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction due to post. op. adhesions</u> <u>5705</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fractured hip 10/17/61 - hip nailed</u> DUE TO (c) <u>— — —</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>10/26/61</u> , <b>19</b> to <u>11/14/61</u> , <b>19</b> , that (I) (we) last saw the deceased alive on <u>11/14/61</u> , <b>19</b> , and that death occurred at <u>10:45</u> P.M., from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>J. Blaine Harrell M.D.</u>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>J. Blaine Harrell</u>		<b>22d. ADDRESS</b> <u>5213 Falmouth Rd. Westmoreland Hills Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>CREMATION</u>	<b>23b. DATE THEREOF</b> <u>11-18-1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR HILL CREMATORY</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>CEDAR HILL, SOUTLAND, MD</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Jas. Lawrence &amp; Sons Inc. Wash. D.C.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 17 '61</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Farris</u>

15051

15051

(M)

## CERTIFICATE OF DEATH

Reg. Dist. No. 12909

12922

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1033 Welsh Drive</u>				d. STREET ADDRESS <u>1033 Welsh Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>NORMA</u> Middle <u>A.</u> Last <u>WHITFIELD</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Aug 18, 1909</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Axel Whitfield</u>				14. MOTHER'S MAIDEN NAME <u>Inga Strom</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>443-40-6339</u>		17. INFORMANT <u>Gary H. Whitfield-Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cachexia</u> DUE TO (c) <u>Metastatic CYSTADENOCARCINOMA OF THE OVARY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Approx 2 1/2 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Nov 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov 26</u> , 19 <u>61</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard J. Meyer MD</u>				ADDRESS (Street, city or town, state) <u>4731 MASS. AVE. N.W. WASH 16, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD J. MEYER MD</u>				DATE SIGNED <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>11/27/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Perry Mount Park</u>		22d. LOCATION (City, town, or county) (State) <u>Pontiac, Michigan</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home-1831 E. Montg. Ave. Rockville, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 29 '61</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12095



DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		NAME OF DECEASED MARY ANN...	
SEX F		AGE 45	
DATE OF BIRTH JAN 15 1890		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION SEWING		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JAN 25 1935		PLACE OF DEATH BALTIMORE, MARYLAND	
TIME OF DEATH 10:30 AM		SIGNATURE OF PHYSICIAN J. H. ...	
SIGNATURE OF REGISTRAR ...		SIGNATURE OF WITNESS ...	
CERTIFICATE NO. 12095		COUNTY BALTIMORE	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 9302 12/4/61 1wk

12923

## CERTIFICATE OF DEATH

Reg. Dist. No. 12910

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>10</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bell Pre Rest Home</b>		d. STREET ADDRESS <b>209 Harrison Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles A. Whitney</b>		4. DATE OF DEATH <b>November 22, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24, 1879</b>
9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR <b>2</b> Months <b>28</b> Days	IF UNDER 24 HRS. <b>28</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Kansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>Thomas Whitney</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Strauss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs Mary W. Kavanagh-Item# 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction &amp; cerebral infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>coronary thrombosis &amp; cerebral thrombosis</b> DUE TO (c) <b>coronary &amp; cerebral arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Prostate</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>1 mo</b> <b>Indefinite</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 2, 1954</b> to <b>11/22/61</b> , that I last saw the deceased alive on <b>11/22/61</b> , and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>11/22/61</b>			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D. <b>Rockville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones- Rockville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>11/22/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 27 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Jones</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED AND READING ROOM - NEW YORK - 1953

CENTRAL INTELLIGENCE AGENCY

1953

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RECEIVED AND READING ROOM - NEW YORK - 1953

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RECEIVED AND READING ROOM - NEW YORK - 1953



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12911

12924

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>13118 Lutes Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1961</u>					
5. SEX <u>M.</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-6-03</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u> Hours <u>8</u> Min.	IF UNDER 24 HRS. Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Epps, Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>526-12-8933</u>		17. INFORMANT <u>Son - 4715 Arbutus Ave., Rockville, Maryland</u> <u>Dennis E. Williams</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic valvulitis, inactive, mitral and tricuspid valve</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-4-61</u> to <u>11-8-61</u> , that (I) (we) last saw the deceased alive on <u>11-8-61</u> , and that death occurred at <u>4:25 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George H. Gray, M.D.</u>				22b. ADDRESS <u>Suburban Hospital, Bethesda, Md.</u>		22c. DATE <u>Nov. 8, 1961</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS		22e. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 10 61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Christina E. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15011

CENTRIFUGAL

15011



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12912

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>169 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Hico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hico</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Zena</b> <b>Zelpha</b> <b>Willis</b>		4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 September 1901</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William F. Minter</b>		14. MOTHER'S MAIDEN NAME <b>Martha Cole</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinomatosis</b> DUE TO (b) <b>Carcinoma of the cervix</b> DUE TO (c) <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>15 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>May 21</b> <b>1961</b> , to <b>November 6</b> , 19 <b>61</b> that (X) (we) last saw the deceased alive on <b>November 6</b> , 19 <b>61</b> , and that death occurred at <b>1:00</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Marvin Pomerantz</b> 22c. PHYSICIAN'S NAME (Type) <b>Marvin Pomerantz</b>		22b. DATE SIGNED <b>November 6, 1961</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Willis Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Grandon Fayette C, W.Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank B. Thomas</b> ADDRESS <b>Oak Hill, W. Va.</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Caroline L. Kious</b>	

(M)

12955

12915

John ...

189 days

the Clinical Center, Bethesda II, Md.

November 8

10 September 1970

West Virginia

William W. Hunter

the Clinical Center, Bethesda II, Maryland

1 month

Continuation of the study

November 8

November 8

William W. Hunter

Continuation of the study

November 8

the Clinical Center, Bethesda II, Md.

November 8

William W. Hunter

11/8/71

Continuation of the study

Oak Hill, W. Va.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

12926 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12913

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		d. STREET ADDRESS <u>315 Boyd Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>315 Boyd Ave</u>				b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RAYMOND <del>BRONKHORST</del> ALTON-Windsor</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-1904</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Prince George Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Hamilton Windsor</u>				14. MOTHER'S MAIDEN NAME <u>Rose Hutchinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Mr. Evelyn Leigear</u>			
17. INFORMANT <u>McConnel Inc. - Kensington Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>11-14-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
<u>Interment</u>		<u>Nov-17-1961</u>		<u>St. Luke's Cemetery</u>		<u>Blacksburg - Va. Md.</u>	
23. FUNERAL DIRECTOR <u>Arthur Walters</u>				24a. REC'D BY REGISTRAR <u>254 Carroll St. N.W.</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>			
				DATE <u>NOV 20 '61</u>			

1531

1532

(M)

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "HAT" and "HAT" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12914

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY CO.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b> c. LENGTH OF STAY IN 1b <b>5+ yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>12111 VALLEYWOOD DR.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b> d. STREET ADDRESS <b>12111 VALLEYWOOD DR.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>YUVONNE PAULINE WOO</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCAS.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 31, 1922</b>
9. AGE (In years last birthday) <b>39 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife, Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Office-worker</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Oregon</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mr. Marvin Blake</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>540-28-1981</b>	
17. INFORMANT <b>Mr. Gayle F. Woo</b>		Address <b>12111 Valleywood Drive Silver Spring, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable pulmonary embolus</b> DUE TO (b) <b>Rheumatic Heart Disease (mitral stenosis)</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <b>410X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>NONE</b> INTERVAL BETWEEN ONSET AND DEATH <b>LESS than 1 hr</b> <b>4+ yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 15, 1961</b> to <b>NOV. 13, 1961</b> , that (I) (we) saw the deceased alive on <b>15 NOV. 1961</b> , and that death occurred at <b>7:45 AM</b> on <b>NOV. 14, 1961</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>G.A. Kelsner, Jr. M.D.</b>		22b. DATE SIGNED <b>14 NOV. 1961</b>	22c. PHYSICIAN'S NAME (Print) <b>DR. G.A. KELSNER</b>
22d. ADDRESS <b>George WASH. Univ. Hosp. WASH. D.C.</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/16/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>
23d. LOCATION (City, town or county) <b>Prince George's County, Maryland</b>		23e. REC'D BY REGISTRAR <b>NOV 16 '61</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>		25. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

(M)

MONTGOMERY CO

MONTGOMERY CO

STAYS

WHEATON

WHEATON

1211 WHITEWOOD DR.

1211 WHITEWOOD DR.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12928

12915

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>46 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Deerfield Beach</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>48 X 3</u> d. STREET ADDRESS <u>804 S.E. 14th Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ruth Alice Wood</u>			<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>19</u> Year <u>19 61</u>		
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>July 5, 1904</u>		<b>9. AGE</b> (In years last birthday) <u>57 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New Jersey</u>	
<b>13. FATHER'S NAME</b> <u>Fred G. Vansyckle</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		
<b>17. INFORMANT</b> <u>The Medical Records</u>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Carcinoid Heart Disease</u> DUE TO (c) <u>Metastatic Carcinoid tumor, primary in ileum.</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 year</u> <u>1 year</u> <u>3 1/2 years</u>		
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that</b> (this hospital) attended the deceased from <u>October 4, 1961</u> to <u>November 19, 1961</u> , that (we) last saw the deceased alive on <u>November 19, 1961</u> and that death occurred at <u>1:10 PM</u> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>Frederick H. Welland</u>			<b>22b. DATE SIGNED</b> <u>November 20, 1961</u>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Frederick H. Welland, M.D.</u>			<b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>23b. DATE THEREOF</b> <u>11/22/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rosedale Crematory</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>NOV 24 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>	

VR A15 (4)  
15M 9/60

(M)

73051

1502

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12916

1. PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington, Md. c. LENGTH OF STAY IN lb 4 mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) LeDeau Gardens		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland d. STREET ADDRESS 8605 McKinley Ct., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Etha K. Young 4. DATE OF DEATH Month Day Year Nov. 2 1961		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 14, 1886 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY In home 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Kountz 14. MOTHER'S MAIDEN NAME Emma Henneberger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No No None 16. SOCIAL SECURITY NO. None 17. INFORMANT Martha McLain Address as above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) Cerebral Arteriosclerosis - Senile DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerotic H.D. - Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 3 days 3-4 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Oct 4, 1961 to 10-2, 1961, that (I) (we) last saw the deceased alive on 10-1, 1961, and that death occurred at 12:55 AM from the causes and on the date stated above. 22a. SIGNATURE William Kurstin 22b. PHYSICIAN'S NAME (Type) William Kurstin 22c. DATE SIGNED 11-2-61 22d. ADDRESS 915 19th St. NW - D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11-6-61 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City, town or county) (State) Hagerstown, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE J. G. Humphrey 25a. REC'D BY REGISTRAR DATE NOV 6 '61 25b. REGISTRAR'S SIGNATURE Arthur E. Kline	

15318

CERTIFICATE OF DEATH

15318

(M)

(1)

2 days

Bureau of Census

General Antirheumatic - 3-4-4

Antirheumatic - 1-2-2-2-2-2

10-2-2-2-2-2

11-2-2-2-2-2

12-2-2-2-2-2

13-2-2-2-2-2

14-2-2-2-2-2

15-2-2-2-2-2

16-2-2-2-2-2

17-2-2-2-2-2

18-2-2-2-2-2

19-2-2-2-2-2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12917

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>4412 39th. Street NW</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Catherine Youngkin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 18, 1886</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>5</b>	IF UNDER 24 HRS. Hours <b>6</b> Min. <b>10</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Newport, R. I.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Edward A. Peckham</b>	
14. MOTHER'S MAIDEN NAME <b>Ellen Dempsey</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>- - - - -</b>		17. INFORMANT <b>HUSBAND: Rodney J Youngkin, Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalopathy</b> DUE TO <b>acute and chronic cerebral vascular occlusion</b> (b) <b>Arteriosclerosis</b> DUE TO <b>6 yrs</b> (c) <b>6-10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>November 7, 1961</b> , to <b>November 9, 1961</b> , that (X) (we) last saw the deceased alive on <b>November 9, 1961</b> , and that death occurred at <b>12:48 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert E. DeForest</b>		22b. DATE <b>November 9, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT E. DEFOREST, LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>13 Nov 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Chevy Chase Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 15 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8103 Kentbury Drive</b>		d. STREET ADDRESS <b>8103 Kentbury Drive</b>	
3. NAME OF DECEASED (Type or print) <b>KENNA D. ZOGRAFOVA</b>		4. DATE OF DEATH <b>Nov. 13, 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/1/1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>12</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Yugoslavia</b>	
13. FATHER'S NAME <b>Gerasimo Serafim</b>		14. MOTHER'S MAIDEN NAME <b>(Unknown) Paraskeva</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Sylvia Brammer-daughter-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pectoris Angina</b> 4-20-61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Arterio-sclerosis</b> 6-00 Interval between onset and death <b>half hour</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5-30</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March, 1957</b> , to <b>Nov 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 10, 1961</b> , and that death occurred at <b>6:08 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Antoinette F. Popovici</b> M.D.		22b. DATE SIGNED <b>Nov 14-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ANTOINETTE F. POPOVICI</b>		22d. ADDRESS <b>Room 319 1835 Eye Street, N.W., Washington, D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/15/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Prince Geo. Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			



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VR A15 (4)  
15M 9/60

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																					
<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>6 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Rockville</u> d. STREET ADDRESS <u>1 5704 Dimes Rd.</u>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>Infant Male HAGINS</u>						<b>4. DATE OF DEATH</b> Last <u>Nov</u> Month <u>30</u> Day <u>19</u> Year <u>61</u>															
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 24 1961</u>		<b>9. AGE</b> (In years last birthday) <u>6 1/2</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>—</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>											
<b>13. FATHER'S NAME</b> <u>IRA HAGINS</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Kathleen Turner</u>															
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u> (If yes give war or date of service) <u>—</u>				<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> (Mother) <u>Same as above</u>		<b>Address</b>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immature</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>P. Pericardial Insufficiency</u> DUE TO (c) <u>—</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>																					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																	
<b>20c. TIME OF INJURY</b> Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-29</u> <b>to</b> <u>11-30</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11-30</u> <b>and that death occurred at</b> <u>4:30 P.M.</u> <b>from the causes and on the date stated above.</b>																					
<b>22a. SIGNATURE</b> <u>A. Jorgensen</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Nov 30, 1961</u>													
<b>22c. PHYSICIAN'S NAME (Type)</b>						<b>22d. ADDRESS</b>															
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>CREMATION</u>		<b>23b. DATE THEREOF</b> <u>12-2-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SUBURBAN HOSPITAL</u>		<b>23d. LOCATION (City, town or county)</b> <u>BETHESDA - MARYLAND</u>															
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>AMELIA C. CARTER, ADMIN. - SUBURBAN HOSPITAL</u> <u>BETHESDA, MD.</u>						<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>													
<b>DATE</b> <u>DEC 11 '61</u>																					

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